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EDITORIAL NOTES

THE LEGISLATURE.

At the time of writing it is impossible to say just what has been proposed in the way of medical legislation, though some things are quite apparent. The usual attempt is to be made to secure special boards of examiners in almost every sort of freak cult. A number of bills have been drawn which may or may not be introduced; one of them provides an entirely new medical law on an entirely new plan, but no copy of the bill has as yet come to our attention. Another proposed law provides for separate boards of examiners for regulars, homeopaths, eclectics, osteopaths, naturopaths and divine healers! An amendment, approved by the Board of Medical Examiners and by the attorneys for the State Society, providing for license without examination in this state of those who have had a bona fide preliminary and medical education not less than that required under our present standards and who have been licensed after a satisfactory examination in their home state, has been introduced. This is the only form of reciprocity that the State Society could possibly endorse. Of course, many of those who have failed to pass the examination of our board are clamoring for a wide-open reciprocity; an amendment that will allow anyone licensed to practice medicine anywhere, to come here and get a license without examination. That is wrong for the reason that there are so many people practicing medicine, and licensed to do so in some one or more states, who never had any medical education to speak of and whose license was secured by merely filing a diploma, which may have been purchased from a "diploma mill" at a cost of from \$50 to \$150. It is only in the last twenty-two years that there has been

any control of medical schools or of medical licensure in the United States, and even now, in many states, what control exists is more theoretical than actual. Many of our legislators do not seem to know these things; many of them seem to think that anyone should have a whack at the business of medicine; they forget that it is a profession dealing with life and death and that the people should be protected as much as possible against incompetence and ignorance.

Oakland (NOT Santa Cruz) is the place of the Annual Meeting of the State Society, April 15, 16 and 17, 1913.

UNPLEASANT PUBLICITY.

It must have been exceedingly unpleasant for Parke, Davis & Co., to have *Pearson's Magazine*, in its January number, come out with a most deleriously hectic article on the phylacogens of our distinguished fellow citizen, Schafer. The house seems to be quite honest in its desire to study these products carefully and to market them in a proper manner. They had quite a correspondence with *Pearson's*, beginning in October 1912, and have sent out copies of these letters in which they most urgently begged the magazine not to publish the article in question. But it was quite too hectic a morsel for *Pearson's* to relinquish. Strange days are come upon us when laymen, in lay publications, instruct the world, or such portion of it as listens to them and is impressed, on things medical. To be sure, the world needs plenty of instruction on things of medicine and of public health; but are the Arno Dosches to do it or are medical men to do it? This sort of misdirected enthusiasm does infinitely more harm than good. But what's the use! It's the old story; "controversy equalizes fools and wise men—and the fools know it!"

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A VALUABLE (?) PUBLICATION.

A most remarkable publication bearing the title of the *Army and Navy Magazine* has reached the JOURNAL office. The December number states that the subscription price is \$3.00 per year, but a careful examination of that issue would lead one to wonder whether anyone would ever pay money for it or if, on the contrary, he would not demand a good price for reading it. There is a department headed "Medical and Surgical," Arthur Gordon Lewis, Editor, and this "department" is certainly a wonder! The new postal law is evidently working well, in this case, for pages and pages of stuff of the reading-notice sort which otherwise might be taken for actual reading matter, are marked "advertisement"; truly valuable "medical" suggestions! Among them we find an article on that delightful fake, "dioradin," written by H. F. Boatman, M. D., Los Angeles, in which he reports a case of advanced tuberculosis "cured" by the dioradin fake; but the article is decorated with

the magic words "advertisement." One wonders whether this is the same article that appeared in the *Southern California Practitioner* last April as an "original" contribution to scientific literature; the postal law does not require medical journals to put the word "advertisement" after reading notices.

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LACK OF COORDINATION.

The potential power of the medical profession is enormous; its actual power is almost nothing; we can never agree and never work together. Time, energy and influence are wasted, frittered away over mere matters of insignificant detail or of phraseology or upon things that do not come within our province but are ruled upon by the courts. It was supposed that this year a larger amount of coordination had been secured; but it was not so to be. Dr. Marlsbary, of Los Angeles, has sent out a circular letter to, presumably, from the number of inquiries that have come to the JOURNAL office, a very large number of people, physicians, lawyers, etc., in which a number of questions affecting medical matters and the medical law are raised. (There is not the slightest intention of questioning Dr. Marlsbary's integrity or the fact that he thought he was doing something for the good of the medical profession; only, it was untimely and should have been referred to the proper Committee of the State Society.) A new definition of the practice of medicine is suggested: "the practice of the healing art for a fee." The courts determine the definition of the practice of medicine and there are a number of good decisions on the subject. Further, one may ask whether, if an appendicitis operation performed for \$1,000 is the "practice of the healing art," what is an appendicitis operation when performed for nothing, called? There are many other questions that could be asked, but what's the use!

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CONGRESS FOR PHYSIOTHERAPY.

The Fourth International Congress for Physiotherapy will take place in Berlin March 26th to 30th and a rather elaborate program seems to have been arranged. The announcement states that American physicians proposing to attend the congress or desiring to contribute papers should communicate promptly with the Chairman of the American Members, Dr. G. Betton Massey, Professional Building, Philadelphia. Many features of entertainment have been provided for the physicians in attendance and for their wives.

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NEW SOCIETY; OLD JOB.

"To put the medical profession on a business basis, obtain new legislation and rid the country of 'quacks' and many abuses now said to be in existence is the hope of the American Society of Medical Economics, which was incorporated at Albany last week," says the *New York Herald*. Good news! The things this new society is going to do, according to the interview with its founder or sponsor, Dr. E. Elliott Harris, are certainly sufficiently numerous and monumental. It will stop fee splitting and secure to every doctor a better income; it will do away with lodge and contract practice; it will stop the abuse of medical charity in hospitals and dispensaries; it will put an end to the advertising quack. Why certainly! These are all evils within the medical profession itself; physicians themselves are to blame for everything complained of as an abuse or an evil, in the list. The way to correct all these evils is simple; just start a society and "do something"! But principally, start a society; call it anything you like, incorporate or not, but start a society! Never mind the fact that what we complain of is something that we, as physicians, are guilty of doing ourselves; never stop and think that if physicians would refuse to do lodge work, there would be no lodge-practice evil; if they would refuse to split fees, there would be no fee-splitting evil; that if they would not be so anxious to get "material" there would be no hospital and dispensary evil. Pay no attention to these things, but just start a society.

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PROSECUTING ILLEGAL PRACTITIONERS.

Some months ago the physicians of Alameda County decided to raise funds, by assessing themselves, for the purpose of getting evidence against illegal practitioners who were then to be prosecuted by the prosecuting attorney for the Board of Medical Examiners. Dr. David Hadden has sent us the report on the work from July 1st to the end of the year. The work seems to have cost from \$140 to \$275 per month, or a total of \$1,252; 45 arrests were made and \$1,200 in fines were paid with one case on appeal in which the fine was \$250. A number of the cases included in the report were cases of abortionists, some of them licensed to practice. It is a singular fact that the people, who should care the most, seem to care the least whether quacks flourish or not and that physicians should have to find the funds for protecting the people who do not care about being protected!

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THE OAKLAND MEETING.

Do not forget that the place of meeting of the State Society for this year (1913) has been changed from Santa Cruz to Oakland. The headquarters will be at the Oakland Hotel, opened to the public in December last, and doubtless most of the meetings if not all of them, will be held in the hotel. The hotel is run on the European plan and the rates for rooms have been fixed as follows: Without bath, single \$1.50, double \$2.50; with bath, single \$2.50, double \$3.50. The restaurant in the hotel is said to be very good and there are a number of other first class restaurants in the vicinity. Owing to the change in the place of meeting, a new Committee of Arrangements had to be appointed and the President, Dr. Hamlin, has appointed the following physicians of Oakland: E. N. Ewer, Chairman; G. G. Reinle, L. P. Adams, J. L. Milton and M. L. Emerson. The Committee on Scientific Work (Program Committee) is hard at work and has arranged a very fine program; the Chairman of the Committee is Dr. Dudley Fulton, Los Angeles. The Eye, Ear, Nose and Throat Section is arranging its own program, the work being done by Dr. H. B. Graham, San Francisco. The Urological Section is arranging its own program under the direction of Dr. Wm. Gross, San Francisco. Definite arrangements as to clinics have not been completed at the time of writing, but it is quite safe to announce that there will be a goodly number of very interesting clinics arranged for one day—or a part of one day—in Oakland and on Friday and Saturday, after the regular sessions of the Society, in San Francisco. It is expected that there will be a very large attendance, as clinical material is always interesting and in addition the program is a particularly attractive one. Do not fail to arrange your affairs so that you can attend this meeting. A preliminary, and more or less fragmentary program will be found elsewhere in this issue of the JOURNAL.

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MEDICAL BUILDING.

Have you thought anything about that suggestion in the last JOURNAL as to the county society owning its own building? It can be done by a good many—if not most—of the county societies in California. You all pay rent to somebody; why not pay it to the county society? It is merely a matter of finance and of getting together, and the getting together, in some places, seems to be the hardest part of the problem. Elsewhere in this issue is the report of the Los Angeles County Association, with a statement of their building plan and a cut of the proposed Medical Building. Look it over. It is well worth your careful study, this idea of owning your own building; and it can be done. In San Francisco, the matter is still being

worked upon and unless petty personalities or dissensions come along and stop it, San Francisco will probably have its own building in the course of time. Unfortunately for San Francisco, it is notorious that scarcely ever can "two or three" be found in that community who will act together and in harmony, and even now it is rumored that a certain number of members of the county medical society do not wish to wait and see if the building scheme will materialize but would have the society immediately attach itself to the worshipers at another shrine. This is most unfortunate because every effort should be made to see if the building plan can be put through (and Los Angeles has shown us that it is *possible*) before any other plan of future development is even considered.

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LODGE AND CONTRACT DOCTORS BARRED.

The San Francisco County Medical Society has, through its committee on admissions, taken a stand that should receive careful consideration at the hands of all our county units. It has ruled that it will not recommend for membership any physician who is connected with lodge work or "dollar-a-month" contract work. The reason for this rule is quite as interesting as the rule itself. The argument is that physicians who are doing this work are, naturally, doing a good deal of work more or less carelessly and that, as any carelessly treated patient may bring a just suit or one which would cost the State Society a good deal of money, it is to the advantage of the society to exclude such physicians from the benefits of membership. The danger pointed out in the reason given by the committee is not imaginary; it is a very real one. We know perfectly well that any physician who is getting about ten cents a visit for his professional work is not going to give it the attention which it deserves; consciously or unconsciously, he will neglect such patients; they will get about ten cents worth of medical care. The San Francisco society is to be commended for its action and similar action is recommended to all our county societies.

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GOING TO BUY AN AUTOMOBILE?

Are you thinking of it? Have you any present intention of buying an automobile or trading off the old one for a new one? If so, and you want to help along your JOURNAL, will you please let us know of your intention? We want to get some automobile advertising on the JOURNAL and we can get it if you will help us show the manufacturers that we are taking an interest in that business.

It will not cost you a cent more than it otherwise would and it will help us, so if you are thinking of getting a car, drop a line to the JOURNAL and tell us what car you are considering; we will help you get it and you will help your JOURNAL. Physicians spend a lot of money in automobiles but automobile manufacturers spend mighty little money in advertising in medical journals. Why should it remain so? There is no reciprocity in that! Is it much to ask of you? Not at all; we will even return the two-cent stamp you use on your letter, if you want it! Will you do it, please?

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BOARD OF CONTROL REPORT.

The State Board of Control, created by the legislature two years ago, issued its first report about the middle of January and, as might have been expected, it found many and divers curious things to report. When one thinks that a number of state institutions, handling hundreds of thousands of dollars, and not provided with any bookkeepers, have not had their accounts investigated or audited for years, one can realize the probabilities! Elsewhere in this issue we publish such portions of the report as refer to medical matters and believe they will be read with interest. The strictures on the Board of Medical Examiners are, in some instances at least, unjust. A very large amount of legal work not at all connected with the prosecution of unlicensed physicians, has been forced upon the attorney for the board; many very important cases, at least one or two of which will eventually go to the Supreme Court, are still in litigation. It is to be regretted that the Board of Examiners did not follow the policy of the State Society and have its accounts audited by a certified accountant every year. In the case of the State Board of Health, the trouble seems to have come from a lack of proper system and no provision for petty cash expenses or what is known as a revolving fund. There are always such small items to be paid out and unless a proper system is employed, confusion is bound to follow. It is scarcely fair to impose business duties upon professional men and then not provide a business-like system; professional men are notoriously careless of business details which they, as a rule, look upon as merely irksome and to be slighted as much as possible. If the Board of Control will keep itself out of politics and not try to indulge in the thousand and one little tricks which seem wedded to political activity, it can do a really great service to the state.

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DUES! DUES! DUES!

If you value the remarkably good protection against alleged malpractice suits which the State Society secures to all its members, do not fail to pay your dues before March 1st, 1913. All members must be reported and paid for before that date or they lose the Medical Defense protection from January 1st. The rule will be strictly enforced; two months is long enough to carry any one. Dues for the year are payable in advance and are due January 1st; see that you pay your county secretary promptly and thus take no chances of being landed with a suit that you will have to defend yourself and that will cost you many hundreds of dollars. The dues are a trifling sum; the cost of defending a suit is no small joke. Do not be careless or forgetful or think you can get along without the aid of the Society. You cannot afford to be unprotected for a single day, for on just that very day, a suit may be filed against you or you may treat some patient who will later bring suit against you. Take no chances; PAY YOUR DUES!

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FRAUDULENT DISINFECTANTS.

The State Hygienic Laboratory has done an excellent work in the investigation of certain alleged disinfectants which are advertised to have extraordinary powers as germ-killers and so are sold to the public; whereas they are in truth and in fact, worthless as such. Dr. Wilbur A. Sawyer, in the Bulletin of the California State Board of Health for November 1912, has an excellent article on this subject. Samples of several disinfectants were tested for the State Board of Control with, in comparison with the claims made for them, remarkable results. In one case the label claimed that "a constant dripping of this oil into the bowls of closets or urinals would disinfect them and would also diffuse a pleasant odor which would kill contagious germs in the air such as tuberculosis and 'all kinds of fever.'" "Examination of the oil showed that dried typhoid bacilli could be soaked in it for at least sixteen hours and would remain alive." And it is for stuff sold by and because of such false and fraudulent claims that people are not only paying their good money, but doubtless in many cases they are placing a false reliance of protection in something that is worthless.

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PROGRAM

Forty Third Annual Meeting of the Medical Society of the State of California

OAKLAND, TUESDAY, WEDNESDAY AND THURSDAY,
APRIL 15th, 16th and 17th, 1913

The Hotel Oakland will be the headquarters, and you should write to the hotel and make your reservation; rooms, without board, from \$1.50 per day up.

The usual arrangement of railroad rates will be in effect; pay your full fare and get a "receipt certificate" for the going trip. Have this receipt signed by the Secretary and you may then get your return ticket for one-third the regular fare.

On Friday and Saturday, April 18th and 19th, there will be clinics in San Francisco, the full details of which will be announced later.

The following is an incomplete and preliminary program of the scientific sessions; days and times when papers are to be read will be announced later.

The following papers have been arranged for the coming State meeting. We cannot attempt, at the present time, to group the papers for the different sessions.

TENTATIVE PROGRAM.

Symposium upon Diseases of the Gall Bladder.

1. Cholelithiasis—Its Pathology. Prof. Wm. Ophuls.
2. Symptomatology of Gall Bladder Diseases. Dr. H. C. Moffitt.
3. Unusual Clinical Features Associated with Gall Bladder Disease. Dr. C. M. Cooper.
4. Pancreatic Complications in Gall Bladder Disease. Dr. Leo Eloesser.
5. Medical Treatment of Gall Bladder Diseases. Dr. Dudley Fulton.
6. Surgical Treatment of Gall Bladder Diseases. Dr. W. I. Terry.
7. Surgical Treatment of Gall Bladder Diseases. Dr. Stanley Stillman.
8. Experiences with Artificial Pneumothorax in the Treatment of Pulmonary Tuberculosis. Dr. F. Fehleisen and Dr. Max Rothschild.
9. Clinical Report on Bacteriology of the Urinary Tract, especially in Relation to Movable Kidney. Dr. David Hadden.
10. Dr. Victor Vecki.
11. Modern Treatment of Fractures. Dr. W. W. Richardson.
12. Management of Fractured Charcot Hip Joints. Dr. Rexwald Brown.
13. New Legislation—In Public Health and Medical Matters. Dr. Wm. F. Snow, (Sec'y Cal. State Board of Health.)
14. Housing Problems. Miss Jessica Peixotto, (Asst. Prof. of Sociology, Univ. of Cal.)
15. Safety Protection of the Laborer. Mr. Aaron L. Sapiro, (Sec'y of Industrial Board of Calif.)
16. School Inspection. Miss A. F. Brown, (School Director of Oakland.)
17. The Diagnosis of Brain Abscess. Dr. J. F. Fisher.
18. The Diagnosis of Surgical Diseases of the Colon. Dr. E. C. Moore.
19. "Pellagra"—A case report. Dr. S. Davidson.
20. "Exfoliative Dermatitis"—Report of a case with recovery. Dr. Thos. J. Clark.
21. "Acne Vulgaris." Dr. Lasher Hart.
22. "The Coagulation Time of the Blood in Diseases of the Skin." Dr. D. Friedlander.
23. "Ringworm in California." Dr. H. Morrow.
24. "Instance of Syphilis, Eczema and Psoriasis of the Palms." Dr. D. Montgomery and Dr. G. D. Culver.
25. Parasitic Skin Diseases in California. Dr. E. D. Chipman.
26. "Presentation of Dermatological Cases." Dr. Harry E. Alderson.
27. Function of the Semicircular Canals. Dr. S. S. Maxwell, Univ. Calif.

Clinics and demonstrations will be given a prominent place in the program. The tentative plan the Program Committee has thus far decided upon is as follows:

Tuesday morning—Presidential address and general reports.

Tuesday afternoon—Symposium on Gall Bladder Disease.

Wednesday morning and afternoon—Clinics and demonstrations in Oakland.

Wednesday evening—Special meetings with papers—(3 or 4).

Thursday morning—Clinics and demonstrations in Oakland.

Thursday afternoon—Reading of papers.

Friday—Clinics in San Francisco at various institutions.

Saturday morning—Clinics in San Francisco.

The following is the provisional program for the Eye, Ear, Nose and Throat Section of the State Medical Society meeting in Oakland the 15th, 16th and 17th of April:

The first day of the meeting will be a joint meeting with the Western Section of the Triological Society, and it is the plan of the chairmen of both societies (Dr. Hill Hastings of Los Angeles and Dr. H. B. Graham of San Francisco) to hold, in addition to the three days' meeting, clinics at the various hospitals and an exhibit of pathological specimens, X-ray plates and new instruments in some central location, on the Monday preceding and Friday and Saturday following the meetings.

Any additions to the program may be handed to the Secretary, Dr. G. W. McCoy, Security Building, Los Angeles, or to the Chairman, Dr. H. B. Graham, 209 Post Street, San Francisco.

The Ductless Gland Extracts in Relation to Ear Affections.

Dr. H. Y. McNaught, San Francisco.
Meningitis of Otic Origin Due to Organisms of the Septothrix Group.

Dr. Henry Horn, San Francisco.
Sclero-Corneal Trephining for Glaucoma (R. H. Elliot). Dr. Kaspar Pischel, San Francisco.
Sub-Conjunctival Injection of Cyanide of Mercury. Dr. A. S. Green, San Francisco.

Iritis; Some Facts of General Interest.

Dr. Vard H. Hulen, San Francisco.
Concerning the Lingual Tonsil.

Dr. M. W. Fredrick, San Francisco.
Thrombosis of the Lateral Sinus with Report of Five Cases.

Dr. Cullen F. Welty, San Francisco.
Tuberculosis of the Middle Ear.

Dr. H. B. Graham, San Francisco.

Mouth and Larynx Signs and Symptoms in Tuberculosis. Dr. H. F. Moore, San Francisco.

Trephining of Eye Ball for Glaucoma—A Clinical and Experimental Study.

Dr. W. S. Franklin, Dr. D. R. Powell.
An Unusual Case of Ophthalmic Migraine.

Dr. E. W. Alexander, San Francisco.
Effects on the Eye of General Pathological Conditions (Case Histories).

Dr. W. F. Blake, San Francisco.
Tuberculous Lymph Glands of the Neck.

Dr. Burt S. Stevens, San Francisco.

Provisional program of the Urological Section and the American Urological Association (Western Branch), which is to be held in conjunction with the California State Medical Society meeting.

The titles of the papers are:

Partial Bilateral Nephrectomy in an Advanced Case of Calculus Pyonephrosis.

Dr. Wm. E. Stevens (by invitation).
Undescended Testes. Dr. R. L. Rigdon.

Treatment of Gonorrhea in the Female.

Dr. Walter S. Johnson.
Pyelography in the Diagnosis of Hydronephrosis.

Dr. Martin Krotoszyner.
Operations on the Closed Bladder.

Dr. Henry Meyer, San Francisco.
Modern Therapy of Syphilis.

Dr. Victor Vecki, San Francisco.

Dr. Krotoszyner wishes to announce that he will demonstrate cases at the German Hospital at time to be arranged in the future.

Papers for Section on Medicine.

Peribronchial Origin of Tuberculosis with Study of Early Cases. Dr. Phillip King Brown.
The Routine Study of Diabetic Patients.

Dr. Thomas Addis.
Sources of Error in Blood Pressure Measurements. Dr. E. S. Kilgore.

Occupational Disease—Aspects of Nitroglycerine Manufacture. Dr. G. E. Ebricht.

Rheumatism in Childhood. Dr. J. A. Colliver.
Unusual Forms of Typhoid Infection.

Dr. W. T. Cummins and Dr. P. K. Brown.
Some Aspects of Tuberculosis. Dr. N. Bullock.

ORIGINAL ARTICLES

TONSILS AND ADENOIDS—THEIR SIGNIFICANCE.*

By GEORGE H. KRESS, B. S., M. D., Los Angeles.

Tonsils and adenoids are among the most important structures in the human body. This statement is made not so much from the standpoint of the known physiological function of those tissues, as from the serious results produced by the pathological conditions to which both are so liable.

In the consideration of tonsils and adenoids, it must be remembered that these structures are only a part of a group of analogous tissues located at the upper entrance of the respiratory and alimentary tracts and spoken of as "the lymphoid ring of Wal-

deyer." This ring of Waldeyer may be said to include the two palatine or faucial tonsils in the back part of the mouth or fauces; the adenoid or epipharyngeal tonsil located in the epipharyngeal or post nasal space; the lingual tonsil situated at the base of the tongue; some isolated lymphoid patches in the larynx, especially about the ventricles and sometimes called the laryngeal tonsil; and some scattered patches of lymphoid tissue in the nose, especially about the lower turbinates, referred to occasionally as the nasal tonsils. To this group may also be added what are called the tubal tonsils, which are patches of lymphoid tissue about the mouths of the eustachian tubes; these latter being, however, regarded by some as only a part of the adenoid tonsils. The term tonsil as applied to these structures has no special significance other than to present the thought of a mass of lymphoid tissue very like that of the two almond-appearing palatine

* Read before the joint meeting of the Los Angeles County Medical and Los Angeles County Dental Associations on November 12, 1912.

bodies nearly always thought of when the term tonsil is used. All these structures in fact may be said to have a histological structure very similar to that found in Peyer's patches in the intestine, or in the solitary lymphoid follicles of the appendix or colon, or in the lymphatic glands in other portions of the body.

Embryologically considered, the tonsils make their appearance about the fourth month of gestation and at birth have a size about one-fifth to two-fifths of an inch in diameter. They reach their full size about the sixth or eighth year, then gradually begin to atrophy so that at the age of puberty, say twelve to fourteen, they should normally be very insignificant structures, so far as external appearances go.

Anatomy of the Faucial Tonsils. The palatine or faucial tonsils are two, each tonsil having a free inner surface facing the fauces or oro-pharynx, the remaining portion of the structure lying in a fossa formed laterally by the sheath of the superior constrictor muscle; anteriorly being bounded by the anterior pillar, which fold of mucous membrane covers the palato-glossus muscle (which when it contracts helps constrict the faucial isthmus and holds the tonsil back in place); and posteriorly being bounded by the posterior pillar, another fold of mucus membrane covering the palato-pharyngeus muscle (the contraction of which muscle helps lift the soft palate as well as also aiding to make smaller the isthmus of the fauces).

At birth the tonsils are often covered by a membrane or plica tonsillaris, but by the end of the first year of life only two portions of this usually remain, known respectively as the upper or plica semilunaris, which often forms also the inner covering of a fossa or recess above the tonsil known as the supra-tonsillar fossa; and the lower or base or plica triangularis.

The external portion of the tonsil, lying on the sheath of the superior constrictor muscle, is covered by a firm capsule, the arteries (tonsillar, ascending pharyngeal, ascending palatine and dorsalis-linguea) entering in the neighborhood of the base or hilum. A plexus of veins covers the tonsils and there is a free connection with lymphatic vessels by which the tonsils are connected with the submaxillary glands and then to the deep chain of cervical lymphatic glands. Von Lénard has also shown a close lymphatic connection of the tonsils with the lymphatic tissue of the nose (as witness sympathetic tonsil inflammation after nose operations) and also with the opposite tonsil; and Grober's experiments of injecting coloring matter into the tonsils have shown its transposition to the neck and bronchial glands and to the connective tissue at the apices of the lungs.

The nut-like bodies known as the palatine or faucial tonsils at maturity have a size of about one inch in length, three-fourths of an inch in width and one-half an inch in thickness. At puberty they undergo physiological atrophy, so that it is claimed that after the age of fourteen a tonsil which appears to be other than a shrunken mass may be looked upon as abnormal.

The faucial surface of the tonsil presents the

mouths or openings of from five to fifteen or twenty glands or crypts, which extend back at times to the capsule and which are lined with pavement epithelium and surrounded by lymphoid tissue such as that already referred to.

Anatomy of the Adenoid Tonsil. As regards the normal anatomy of the adenoid tonsil or Luschka's tonsil or the epipharyngeal tonsil (by which latter names it is also known) we have to consider only some discrete patches of lymphoid tissue held together by a network of connective tissue and located on the wall of the epipharyngeal space, especially in the mid line region; and covered by columnar epithelium, some of it ciliated and pierced by a few mucous glands. This tonsil of Luschka, so named because it was Luschka who with Kolliker in the seventies described this tissue histologically, really becomes, when it is in a morbid state, what is popularly known as an "adenoid" or "adenoid vegetation."

Luschka's tonsil is then a normal structure only when its own size is in proper relation to the surrounding spaces and tissues, and becomes an abnormal tissue or so-called adenoid when it assumes a change of structure and size, be that size large or small, sufficient to make it interfere with the normal condition and function of the epi-pharynx.

Adenoids are not usually noticed until the age of three to ten, but that does not mean that they are not present before that time, for we know of one surgeon of our own city who has operated, with much benefit, on at least a dozen patients of one month of age or so in the last few years. Luschka's tonsil while usually noticed between the ages given is less frequently seen after the age of fifteen because of the physiological atrophy which it usually undergoes with the advent of puberty.

Physiology of the Adenoid Tonsil. Of the physiology of Luschka's tonsil little is known and at most we can only affirm perhaps that the ciliated epithelium helps keep the secretions in proper motion; the mucous secretion adding its share of moisture to the respired air and the lymphoid elements performing the usual function of lymphatic gland tissue.

Physiology of the Faucial Tonsils. The physiology of the palatine or faucial tonsils has been more studied but cannot be said to be much more settled. The case of true and demonstrable physiological function of the palatine tonsils cannot yet be affirmed to have been made out. Among the possible functions which have been put forward for the palatine tonsils are the following:

1. That it is a modified lymph gland, and that it wages war against germs by means of its lymphocytes and secretions.

2. The view of Bordley that these tonsils have an internal secretion which helps regulate the ductless glands of the body.

3. That these tonsils in conjunction with other structures in the naso-pharyngeal lymphatic chain may produce substances in early life which have to do with the proper development of the facial bones and cavities.

4. That they may have a part to play in the modulation of the voice.

5. That they help moisten food in preparation for deglutition and perhaps throw out a ferment having an influence on the sugars.

6. That in the early years of life they may play a part in the production of the blood.

7. That it is a residual or vestigial organ with no real function of importance.

Of the above theories, we can agree that food particles are probably moistened and thus the tonsils are perhaps of some aid in the act of swallowing. It is probably not a residual organ because the tonsils are larger in human beings than in almost all other animals. They may be and probably are protective barriers against germ infection when they are in a state of health, but as the tonsils seem more often to be abnormal than normal, even the value of this function of phagocytic protection is minimized. The other theories may be passed over as having in no sense been proven. This certainly leaves no over-great amount of physiological function as a reason why our palatine tonsils should not be removed when they are abnormal or diseased.

Physiology of the Mouth, Nose and Pharynx. Before taking up the symptoms of abnormal adenoid and faucial tonsils it may be well to consider for a moment the physiologic functions which are especially interfered with when these structures take on abnormal characteristics. The three functions especially involved in diseases of the oro-naso-pharynx are those of respiration, swallowing and phonation.

As regards respiration, we must consider first normal or nasal respiration and second, abnormal or mouth respiration. In quiet normal or nasal respiration the mouth is closed off from the pharynx because the tongue and soft palate approach one another, so that the air must pass from nose, into pharynx and then into the larynx.

In abnormal or mouth respiration, in order to permit the air to get into the larynx the tongue and palate must separate, the palate in this act rising higher to lie against the posterior pharyngeal wall.

As regards phonation or voice modulation, we have to consider the nasal consonants or sounds like m and n on one hand and the ordinary consonants and vowels on the other. In the production of nasal sounds the soft palate hangs down in a flaccid state, so that the nasal air column may be set in vibration; but in other sound production, the soft palate is usually drawn up so as to almost cut off the nasal cavity.

As regards swallowing, the food is received by the tongue and pushed back, the hard palate first offering the necessary counter-resistance and the soft palate rising in addition, so as to close off the nasal cavity, while the larynx is pulled up and protected by the epiglottis.

It is then these functions of proper breathing, speaking and swallowing that are so frequently involved, locally, in the abnormalities of the faucial and adenoid tonsils, which can now be considered.

Etiology of Tonsillar Abnormalities. Before taking up the symptoms of diseased conditions of

these structures it may be asked what are the etiologic factors which play a part in the production of such abnormal states of the tonsillar tissues.

In a general way faulty hygiene, and unfavorable climatic environments, with a certain amount of hereditary predisposition may be said to all play causative roles.

Since adenoid and faucial tonsils are structures normal to the body at birth, the question of the influence of heredity arises. It would seem that parents who have had morbid conditions like tuberculosis, syphilis, malaria and similar debilitating diseases are more apt to transmit a decreased resistance to their offspring, resulting in a hypoplasia of tissue structure in such children, associated frequently with an hypertrophy of lymphoid structures in which the tonsillar tissues of Waldeyer's ring are more or less involved.

Outside of this hereditary influence just mentioned anything that produces a so-called cold or coryza in children may bring about a vicious circle that finds expression in disease of the tonsillar structures, with their resultant consequences. Faulty body and home hygiene are then of first importance as causative factors, for all must appreciate how miserably, from the hygienic standpoint, our infants and children are clothed, bathed, fed and exercised and how greatly these factors, with improper methods of ventilation, favor the production of one naso-pharyngeal cold or coryza after another. If with these, is associated a damp, unpleasant climate and improperly heated and ventilated homes and school rooms, the tendency to such inflammations of the naso-pharyngeal mucous membrane is still further increased.

Each attack of such an inflammation in infants and children (who do not know how to clear their nasal passages by blowing, and whose physical lives from day to day are filled with extra burdens thrown on their digestive and eliminative functions), means a greater or less change in the structure of the mucous membrane lining the naso-pharyngeal tract and especially in the lymphoid tonsillar structures which are called on, in these inflammatory states to absorb and get rid of the deleterious secretions associated with such conditions.

No wonder that in the recurrence of one after another of such too frequently produced and nearly always improperly treated colds, the burden on these lymphoid tonsillar structures becomes so great that they find it impossible to return to their normal inoffensive size, structure and function. And once these tonsillar tissues so change in size and structure and function, so as to mechanically and physiologically interfere with the proper work of breathing, swallowing and speaking, a vicious circle is established which still further favors the production of the symptoms now about to be enumerated.

Some of the symptoms of enlarged faucial and epipharyngeal tonsils or adenoids will be considered together, since in many cases adenoids are present when tonsils are hypertrophied or vice versa, and since in some respects they act analogously in the production of symptoms.

The manifestations of mechanical obstruction to respiration may be said to be the more important as regard the adenoids, whereas in the tonsils, the abnormalities resulting from absorption and degeneration seem to play the larger role. The picture presented by children with these tonsillar overgrowths varies greatly in degree and it must be remembered, as already stated, that the large size *per se* of a tonsil or an adenoid is not of so much importance as are their size in proportion to that of the surrounding spaces; nor is the size itself a matter of moment when mischief arising from secondary infection is serious or frequent. A small adenoid in a small and crowded epipharyngeal space may then be much more of a mischief maker and interfere far more with surrounding functions, than a much larger adenoid located in a relatively capacious epipharyngeal space. A similar analogy may be said to exist as regards the tonsils.

In considering the palatine tonsils, the symptoms of acute follicular tonsillitis or supratonsillar abscess will not be taken up, other than to state that repeated attacks of such diseases should in themselves be indications for the enucleation of such tonsils.

Luschka's tonsil when enlarged sufficiently to be worthy of the name "adenoid," may be of a firm or true hyperplastic structure or of a soft or villous form known as an adenoid vegetation, marked by furrows somewhat after the shape of the brain convolutions.

Symptoms—Especially of the Adenoid Tonsil. As a result of either type of enlargement, the epipharyngeal space is partly obliterated by the adenoid, so that less air can pass through this channel. As a consequence nasal respiration becomes more superficial and so also does pulmonary respiration, and with the poorer pulmonary respiration goes a poorer development of the pulmonary tissue itself, especially at the apices.

It must be remembered that the bones of infants and children are comparatively soft and pliable and that they respond most easily as regards their growth and proper development, according as the functions for which they were intended are properly brought into play. Thus the superficial nasal respiration with its secondary superficial pulmonary breathing brings about the production of more or less round shoulders and a stoop in the gait. The condition known as pigeon breast also often results. It will be seen that other changes in bone conformation result in analogous manner in other regions.

The obstruction to proper nasal respiration causes an accumulation of secretion in the nasal passages and when this is irritating, an eczema of the upper lip is produced. The blocking of the epipharyngeal space causes a certain amount of compensatory mouth breathing, proportionate somewhat to the amount of nasal respiration done away with.

This oral breathing brings to us our patients whom we classify as mouth breathers. If the train of symptoms stopped with this lone cosmetic deformity the condition would not be so serious, but that is just the beginning of a real vicious circle of malformations and malfunctions. With this open mouth, to permit of the necessary intake of air

through the passage, go a drooping jaw and receding chin, and flaccid facial muscles, so that the facial folds that have so much to do with expression are obliterated.

Owing to the comparative non-use of the nasal passages, the stimulus to proper development of the facial bones which comes from use of the muscles and tissues in nasal respiration is much diminished, and because of this non-use and associated lack of stimulation, serious changes and deformities in the developing soft bony tissues of the face result. Thus the development of the upper jaw is seriously interfered with, the dental arch fails to assume its normal shape, the teeth have a tendency to overlap, the incisors often pushing forward and the canines somewhat outward. This protruding upper jaw and high, narrow, and V-shaped arch of the palate is often quite pronounced in some patients. Often the teeth have a tendency to erupt higher up, and in a crowded and irregular manner.

The retained and decomposing nasal and pharyngeal secretions favor the invasion of these tissues by bacteria and as a consequence these children have more caries of the teeth than is usually the case, Manciola stating that the upper incisors and lower molars are especially apt to be thus affected.

The sinuses of the facial bones do not develop properly because they, too, lack the stimulus that comes from the air currents present in normal nasal route breathing.

It is possible that such a matter as faulty hygiene in feeding infants may also be at fault in the development of the facial bones. Barnard has called attention to the fact that artificially fed children are more predisposed to adenoids than those fed at the breast. A child taking milk at its mother's breast draws long inspirations which help keep the nasal passages free of secretions and which may have in this manner a considerable part to play in the proper circulation of the nasal tissues and in the development of the surrounding bones. Infants fed on the bottle, on the contrary, do not usually breathe as deeply, and as now-a-days so many infants are bottle-fed, this may account in part for the seeming increase of adenoids among our children.

Because of the increased secretions from the adenoid tissue and the retention of nasal secretions, there is a tendency, especially at night, for these secretions to drop downward, and in that way they lead to a descending catarrh of the mucous membranes, with resultant catarrhal pharyngitis, laryngitis and bronchitis, and the air inspired through the mouth, being devoid of the moisture usually given to it by the nasal mucous membranes still further accentuates this catarrh of the bronchial tree.

Many of these children manage to breathe through their nostrils during the day time, but at night, in the recumbent position, when the muscles are relaxed and the circulation more sluggish so that the parts are more engorged with blood, the child joins the ranks of the true mouth-breathers. This mouth breathing is but a poor substitute for nasal respiration, however, both as regards quantity and

quality, and as a consequence these children at times, especially during their sleeping hours, literally have an air hunger; so that such children are restless in their sleep, may have night terrors, night sweats and nocturnal incontinence of urine. The superficial breathing means resultant inferior oxygenation of the blood, and the restlessness prevents the child from getting a refreshing sleep and these two thus bring about an impoverished blood or anemia and a real feeling of being tired and sleepy when morning comes. No wonder such children seem stupid. Under the same conditions, grown-ups would present a similar picture. The anemia may be increased when the lymphoid follicles are at the same time also foci of septic matter.

A very serious result of adenoid growths is the involvement of hearing, some authorities contending that by far the greater proportion of middle ear catarrhs and suppurations in children have their origin in adenoids. Earaches and catarrhs of the eustachian tubes and middle ear, with resulting deafness are therefore especially frequent in these children. The deafness resulting from adenoids may come about in a number of ways. There may be direct obstruction of the mouth of the eustachian tube so that the tube cannot drain properly. Or the adenoids may press on the tubal muscles so that it is difficult to keep the air in the tube and middle ear of the same pressure, as it is on the other side of the drum, in the external auditory canal. Or the inflammation of the mucous membrane of the adenoid may by extension involve the lining membrane of the eustachian tube and middle ear. Again, adhesive bands may be formed. The increased nasal secretion and the increased effort to get rid of it, as well as the increase in the infective power of this secretion, makes more liable, also, infection of the eustachian tubes, by insufflation of such material, during efforts to clear the nose.

Probably twenty-five per cent. or more of all children have some deafness and in the big majority of these cases, this deafness probably had its initial start in adenoids. The prevention and treatment of adenoids, from the standpoint of conservation of hearing and economic utility is therefore of tremendous importance.

The stupid and expressionless faces of these children are nearly always fair reflections of their mental capacity and intelligence. This mental stupidity has been given a special name by Guyé of Amsterdam and is called *aproxexia*, one of its distinguishing features being an inability on the part of the child to concentrate its attention, due, it is thought, to an interference with the circulation of the brain. Part of the inattention is, however, often due to the associated deafness. These children not hearing well, they cease to pay attention and in that way their listlessness and indifference is emphasized.

Owing to the change of form in the epipharyngeal space and the interference with the proper muscle movements of the palate, these children often talk with a nasal twang, a dead voice as it were, and some even have a tendency to stammer.

The enunciation of some of the consonants is especially difficult.

Interference with the sense of taste; a cough from the inflammation of the bronchial tree; nose bleed from picking at the crusts and irritating nasal secretions; gastric disturbance from swallowing the nasal secretions; fetid breath from the decomposing secretions; and reflex nervous symptoms of neurosis and irritability are other symptoms which have been noticed. One observer has also called attention to the frequency of conjunctivitis in those children. It is to be remembered, however, that all mouth-breathers are not necessarily stupid mentally, nor that all children with adenoids, present the typical features of mouth-breathers.

For, it must be remembered, children are found who show little else than underweight and listlessness and who seem to have no normal capacity for increase of strength and vitality—a condition of hypoplasia as it were—in whom no other cause for the lack of growth and development can be found than possible foci of infection in the tonsillar tissues. The fact that groups and schools of such children have been shown to improve greatly, both physically and mentally, after the enucleation of tonsils and adenoid tissue seems to bear out the contention that those tissues were really playing a decided part in the production of the hypoplastic condition of these children.

The symptoms given up to this point are those which usually go with adenoids, although in milder degree they may also be expressive of hypertrophy of the faucial tonsils.

Symptoms and Results—Especially of the Faucial Tonsils. The special significance of diseases of the tonsils lies in the fact that they can not only set in motion the train of morbid phenomena just given, but that over and above that, they can be the entrance doors by which a large number of serious infections can gain access to the general system. For it must be remembered that the tonsils if not actually lymphatic glands, are closely related structures of the type perhaps of the thymus glands, and that whichever the case may be, there is an intimate connection with the lymphatic vessels and circulation of the body, so that it is comparatively easy for infective material to be carried to other lymphatic spaces such as the joints or muscle sheaths, or to get into the circulation, and at places where the proper conditions obtain, to set up secondary infections. Many of these infections are of a septic nature, as would be expected somewhat from the light which bacteriologic researches have thrown upon the nature of the micro-organisms found so oftentimes present in diseased tonsillar tissues.

Prominent among these secondary infections or complications or sequelae of diseased tonsillar structures is tuberculosis of the cervical lymphatic glands, there being in this particular complication an additional possible role as a route of infection for pulmonary tuberculosis.

The causal relation with rheumatism is too frequent to be ignored and it has been stated that Barker of Johns Hopkins has tonsil enucleations

done on nearly all of his rheumatic patients, before they leave the hospital.

Bronchitis, pleurisy and pneumonia; endocarditis, peri and myocarditis; myositis; neuritis, phlebitis, osteomyelitis and nephritis have all been shown to have arisen in persons in whom diseased tonsils seemed to be the only portals of entry for these infections and diseases.

Scarlett of Philadelphia in a series of appendicitis cases showed that fifty per cent. of the cases had suffered from previous anginas.

In a goodly number of patients with tonsils and adenoids, the temperature, if carefully taken at frequent intervals, will show an increase over the normal. Here, also, the explanation is probably to be found in a focus or foci of infective material.

Other diseases of a septic nature have also been brought forward but enough have been mentioned to show that the menace to health and life from this source is undoubted and serious.

The far-reaching and grave effects of tonsils and adenoids having been shown a few words concerning diagnosis and treatment may not be out of place.

Diagnosis.—The diagnosis is made on the symptoms and signs just given, it being kept in mind that the picture may vary from the hypoplastic, underweight child who seems to be a mouth breather, to the typical mouth breather with adenoid facies. In the diagnosis, the use of the post-pharyngeal mirror permits often a fairly good view of the adenoid tissue. Far less often, these structures can be seen through the nose. The finger, passed into the post-pharyngeal space often gives even more valuable information than either of the above. But the verification of the diagnosis of adenoids by these latter procedures, all of which have a tendency to frighten a child, unless most gently done, would not seem to be absolutely necessary. The operation for removal of the structure is warranted when the symptoms previously outlined are present in whole or in good part, and when no other process can be found to account for the same.

Treatment. What is the treatment for diseased tonsils and adenoids? One word tells the story and that word is "removal."

The adenoids may be removed by one of the more modern adenotomes or by a curette, either the original Gottstein pattern or one of its modifications. If in the course of several years this adenoid tonsil again hypertrophies (that is, continues to grow, in spite of its previous excision, as is apt to be the case in very young children), then remove it again as before.

For the tonsils, a host of methods of removal have been brought forward. In America the tonsillotome or guillotine, by means of which only the top or free portion of the tonsils are removed, is being rapidly discarded, so that to-day, as a rule, only the operation of complete removal or enucleation is that which is attempted. It must be acknowledged, however, that the supposed complete enucleation or tonsillectomy is often only a partial removal or tonsillotomy. But even partial re-

movals have at times been productive of much improvement in the condition of these patients.

We believe with those who are in favor of a complete removal and advocate the use of this operation on a liberal basis, our ground for so doing being the havoc which tonsils and adenoids can produce, as already outlined in this paper.

And yet it is proper to state that the operation for complete removal is by no means accepted the world over. In Germany, only a few months ago, in a discussion which we had with Professor Kilian, that authority pooch-pooched the Sluder operation and we saw only the old-fashioned guillotine or partial removal tonsil operations in his clinics. And in speaking to his first assistant, Albrecht, when we told him of one American operator, Sluder, who probably did about four or five hundred tonsil enucleations per year, we received the reply that that number of tonsil enucleations ought to be sufficient for the whole world. We were personally never able to accept the reasons of the Berlin authorities for their preference for tonsillotomy, which seemed to be based on a fear of greater or more serious hemorrhage from tonsillectomies than from tonsillotomies, and upon certain supposedly deleterious traumatic or other effects in complete tonsil removal.

By contrast to this, however, in the big Chiara Clinic in Vienna, virtually the only operation done was that of enucleation, and here, in order to permit us to try out the Sluder enucleation or evulsion method, they brought us little children, the nurse wrapping only a sheet about them to hold them, and then with mouth gag in place and no anesthetic whatever we were told to go ahead and evulse the tonsil by the Sluder method. We confess this latter somewhat cold-blooded procedure seemed almost as much an extreme in the one direction, as the Berlin teaching seemed to be in the other.

The method which we ourselves like best is the quick or "rausch" anesthesia with hot ether, and enucleation by dissecting away the upper and lateral poles of the tonsil with a curved semi-blunt dissector, and removal of the tonsil mass with the cold snare. This operation in virtually every instance can be made to bring out the tonsils in capsule and can be as rapidly done as any other method we have ever witnessed, the method of Sluder as we have seen it done by himself being no exception. With this method of partial anesthesia, the patient is usually semi-conscious before he reaches his room from the operating table.

To our viewpoint, a most important item in operative treatment, is the education of the child, after the operation, in proper methods of nasal respiration. This is accomplished by certain breathing exercises and attention to nasal hygiene.

This, then, presents our case, as we wish to make it, against diseased tonsils and adenoids.

Our inability to find an important physiological function for the structures should not lead us to advocate their treatment by ineffective local applications, when we have before us the host of deleterious immediate and remote effects they can bring into operation in the human organism.

Statistical evidence everywhere goes to show the wide prevalence of these diseased conditions of tonsils and adenoids in our children and proves equally well the beneficent influence of proper surgical intervention on the organisms and general health of such children. To advocate a wait to see if the tonsils will atrophy spontaneously, is to advocate a procedure not warranted by our present knowledge.

Think for a moment, of the large number of human beings who as children had adenoids and diseased tonsils and which were neglected, so that the physical and mental development were so seriously retarded that these individuals, in consequence thereof, and the deafness so often associated therewith, were relegated to lower places on the social and economic ladders than would have been the case had they received proper operative treatment!

Surely the crosses which this host of fellow beings unnecessarily are made to bear, leaving out of account all other reasons, should be sufficient to make us look upon properly indicated adenectomies and tonsillectomies as of the highest economic and social significance and worthy of the broad exploitation these subjects are now receiving. And in this work of education we feel sure that our colleagues of the dental profession will be more than willing to do their part.

OPERATIVE TREATMENT FOR TIC DOULOUREAUX OF THE INFERIOR DENTAL NERVE.*

By CHARLES G. LEVISON, M. D., San Francisco.

I desire to state that in this paper there is no intention to discuss the relative merits of the different forms of treatment for inveterate neuralgia of the inferior dental nerve, for it is accepted that certain methods of treatment such as injections of alcohol, etc., are sufficiently effective as palliative measures to satisfy the patient, even if their results are not permanent.

The patients here considered are those who have been subjected with more or less indifferent success to all of the accepted methods of treatment, and who in despair apply for relief; it is in this class that surgical intervention should be resorted to.

Resection of the inferior dental nerve is not difficult when carried out according to the methods generally advocated, but the end results are not satisfactory. As far as the simplicity of the operation is concerned this is quite true, but under ordinary circumstances the operation is incomplete, so that after a year has elapsed there is often a recurrence of the pain and as the patient does not return, it is assumed that a cure has been accomplished, when as a matter of fact this is not the case. With the resection of this nerve as it is usually carried out, recurrences are almost as frequent as after alcohol injections.

The points that I desire to emphasize have no claim to originality but consist of a few procedures that make the operation complete so that a permanent cure can be effected.

The operation has for its object the complete removal of the entire inferior dental nerve, including its extreme ramifications which have their endings in the mucosa of the lip. The incisor branch, which is a continuation of the dental nerve beyond the foramen and which goes to the incisor teeth, should also be removed from its canal. When the nerve is removed in its entirety, if it is the only one involved, a permanent cure is effected.

The usual methods advocate the removal of the inferior dental nerve in its canal, laying no particular stress upon the removal of the incisor branch or the filaments that go to the lower lip and its neighboring tissues.

I believe, and my experience has borne this out, that even if the entire inferior dental nerve in its canal is removed, and if the branches as they pass into the tissues are not withdrawn, a permanent cure does not always result, for in one instance the entire inferior dental nerve was removed from its origin to the mental foramen and the pain was not relieved until the filaments going to the tissues of the lip were avulsed.

Operation: The following method has been developed after numerous experiences, and while it may be slightly more difficult than those generally advocated, in my opinion it has been followed by more satisfactory results.

A small incision is made through the mucosa between the two bicuspid teeth at their roots, which readily uncovers the mental foramen together with its nerves and vessels; the stump of the nerve is grasped with a firm hemostat, when the nerve together with all of its ramifications, which are numerous, are avulsed from the tissues of the lip; this avulsion is easily done by pushing the tissues away from the nerves, which are quite large and very strong and can be firmly held by the hemostat.

These nerve endings are remarkably large and their size will surprise one who has never removed them in this way. They extend deep into the tissues of the lower lip as far as the vermilion mucosa. The nerve can generally be extracted intact with all of its endings. After it has been entirely freed from the lip and all of its branches withdrawn from the tissues, then the inferior dental nerve can be removed from the canal; this is done in the following manner:

There is a spine forming part of the mental foramen at its distal side called the "lingula" which has to be chiseled off, otherwise it is impossible to introduce a probe or any instrument into the canal;

* Read before the California Academy of Medicine, September 2, 1912.

after this is done, and it should be done under illumination, for it is easy to sever the nerve with the chisel as it makes its exit; if the nerve is severed no harm is done, but it is more satisfactory to remove it intact.

After the overhanging shelf has been chiseled off, a wire 1 mm. in diameter, having a certain amount of spring and barbed so that the barbs are directed towards the handle, is introduced into the canal and pushed upward until the point can be felt at the upper opening on the inner surface of the ascending ramus of the jaw as the nerve is given off from the inferior maxillary nerve; the handle is then slowly turned around its own axis, care being exercised that the instrument is not twisted, otherwise the wire will be so twisted as to break off in the canal; it is important that the instrument be turned slowly so that the barbed end will engage the nerve. After the instrument has been rotated eight or ten times very slowly upon its own axis, the sensation of the nerve tearing away is readily felt when the whole nerve is withdrawn from the canal more or less intact. The nerve canal can then be felt empty of its contents when the probe is introduced.

A point of importance also is to avulse the incisor branch of the nerve which is a continuation of the inferior dental nerve that passes to the two incisor teeth; this should also be withdrawn by a barbed-pointed instrument, the same as the one just described. Alcohol may be injected into the canal, but the results are practically the same if the nerve has been thoroughly removed.

Note: It was Dr. M. H. Woolsey who first called my attention to the method of removing the nerve from the canal by means of the barbed wire.

Discussion.

Dr. Hyman: Do I understand that with ordinary resection the pain does not cease?

Dr. Levison: It does but it recurs after a year or so practically as after alcohol injections. I operated in one case and despite the fact that the inferior dental nerve had been removed, the pain did not disappear until the filaments of the nerve in the lip were avulsed.

In answer to Dr. Wilbur I want to say that the first operation of this kind that I performed was prior to the time when alcohol injections had been introduced; at that time the usual procedure in tic douloureux was to trephine at the angle of the jaw and extract the nerve from its canal. As far as immediate effect was concerned, this was satisfactory and the patient remained well for a time. I have had several experiences of this kind. I advocate operation in a certain class of cases, for example:

The woman whose nerve I am here demonstrating was treated by numerous alcoholic injections given by competent people. She had reached the point where she felt that something else had to be done; her attitude was characteristic of those suffering from inveterate neuralgia of the inferior dental nerve; she could not open her mouth, neither could she speak nor eat on account of the severe pain that these motions produced. The area on the chin opposite the exit of the mental nerve was red and she held her handkerchief to this point constantly. She was ready to submit to anything but further alcohol injections. It is for these patients that operation is advocated; it is not associated with any mutilation and is really much easier to perform than to describe.

SOME FACTORS IN HABITUAL CONSTIPATION.*

By RAYMOND RUSS, M. D., San Francisco.

The center of surgical discussion shifts from time to time. The brain, the neck, the thorax, occupy in turn the circle of the spotlight, which may be switched at any moment to some other portion of the stage of endeavor. Surgery, constantly trying to increase its scope, has fads and fancies. The opening of a new field is always followed by a stage of over-enthusiasm and sometimes reckless and ill-considered operating. Concomitant causes are lost sight of in the presence of what is thought to be a newly evolved principle, so desirous are we of reducing our asset of painful experience to the proportions of absolute, scientific fact.

Until recent years our conception of the large intestine was that of a receptacle in which waste products were stored before their evacuation. The experiments of Cannon and Barclay Smith established a definite function for the first portion of this tube; with this focusing of attention came a discussion of habitual constipation which primarily concerns it. The work of Wilms, Lane, Jackson, Fischler and others is so well known that we will not comment on it; suffice to say that besides ptosis, various adhesions and membranes have been found throughout the length of this large tube and that the view is growing with many men to regard certain forms of habitual constipation as purely mechanical, and this class believe that in many instances direct interference offers the only remedy.

Bismuth meals and X-ray pictures of the large intestines are becoming common but many and most serious errors have resulted from their interpretation. While the surgeon may profit by his mistakes, the patient does not. Too frequently he pays the penalty of ill-timed enthusiasm. The X-ray is teaching us that we must abandon our mental picture of the large bowel in health; that there is a difference in location between the standing and the lying positions; that the colon may be entirely within the pelvis of a woman in normal health; that the length of the ascending colon varies within wide limits and that the cecum is most variable in size and position. These are some of the things that a careful study of X-ray plates is showing but the strange part of it is that we already possessed this anatomical knowledge.

The wonderful strides that surgery has made are so impressive that we are prone to forget its shortcomings. We have long believed that the most serious blow the subject ever received was when it was divorced from anatomy. Few surgeons of

* Read before the San Francisco Polyclinic Society.

the present have the anatomic equipment for their work possessed by those of yesterday. The result is apparent in the surgery of the large bowel as it is in other fields. A better anatomic knowledge would have saved many a blunder which has already been committed in the operating room.

This is our excuse for considering to-night some anatomical facts concerning the large bowel and their bearing on habitual constipation. The subject is so extensive that it will be impossible to consider it from all its standpoints and, as these various phases are closely correlated in the etiology, our remarks will not possess sufficient breadth to make them satisfactory. Anatomical textbooks have in general poor accounts of the large intestine and it will be necessary to revert to original articles in order to gain the necessary knowledge for surgical interference.

The cecum may be defined as that portion of the colon which is situated below the entrance of the ileum. Its average length in the adult is given by Berry, Treves and Lardenois as 6 to 7 cm., its average width is 7.5 to 8 cm. and its capacity is from 200 to 300 cc. The various shapes to be found in the human cecum are well shown in textbooks and do not concern us here, but differences in size and position are questions of moment. That the apparently normal cecum is capable of great variation in size is known to every active operator. Byron Robinson in 435 autopsies states that congenital absence of the cecum and appendix was met with in but one case and that he found excessively large cecums in a little less than one-third of all autopsies. The latter statement must be taken with some reservations for the autopsy should be made immediately after death; ballooning of the cecum will sometimes occur soon after rigor mortis has set in. Very small cecums are frequently encountered and this no doubt results from diminution of the blood supply during axial rotation and cecal descent.

The size of the cecum bears no relation to the height or weight of the adult. In the first few months of fetal life the development of the small intestines, as would be expected, is out of all proportion to that of the large bowel. There is little or no growth in the colon for the first four months of extra-uterine life. According to Legueu cecums of 7 to 8 cm. in length and longer are not uncommon in infants, but in general it may be stated that the length of the cecum augments with the age of the individual until full development is reached. Tarenetzky believes that the cecum continues to increase in length with age, but this statement does not conform with the observed facts.

Most commonly the cecum is found lying upon the psoas muscle with its apex, or lowest point, projecting but slightly beyond its border. Less

frequently the cecum lies upon the iliacus muscle. In many instances the cecum is found not upon either of these muscles but quite clear of them and hanging down into the pelvis. This fact is well known to all surgeons. In 18 examinations out of 100 Treves found the cecum in the pelvis. Lardenois, in 80 subjects examined, found the cecum more or less inside the pelvis in 9 and Alglave in 100 subjects found the cecum 17 times resting on the pelvic floor. According to Byron Robinson the cecum is twice as often in the pelvis in women as in men, 20% in the former and 10% in the latter. Properly speaking there is no such thing as a mesocecum. Cecums of normal or large size float freely and enjoy a considerable amount of movement. Small ones are usually fixed, while those of considerable size are frequently found in the pelvic cavity or in the middle of the abdomen. Stierlin states that mobility of the cecum was observed in from 10% to 23% of a series of cadavers in which all evidence of intestinal trouble was lacking. In 11 bodies out of 100 free from abdominal disease, Treves met with cecums that could be made to touch the under surface of the liver and any part of the left side of the pelvis. Dreyer in a large number of autopsies found a movable cecum in 67%; the frequency with which the cecum may be raised to the height of an upper abdominal wound is well known.

The normal or large cecum floats clear of attachments ready to take any position to which a fluid content may depress it or a gaseous content buoy it. Its upper limit is marked by an incomplete groove and angulation is apt to occur at this point. In 94% of cases the cecum is fully covered with peritoneum as is also the first portion of the ascending colon. From the tip of the cecum to the beginning of the mesocolon, there is, in the greater number of instances, a space of 10 to 11 cm., thus affording an organ, frequently out of all proportion to the size of its container, the opportunity of adapting itself to the position of the other viscera. In addition, the mesocolon is sometimes found to be stretched, thus affording a still greater excursion.

We find then that the normal cecum varies greatly in size, that it is freely movable and that its contents, whether liquid or gaseous, will determine to a great extent its abdominal position; that it rests generally on the psoas muscle, although it often lies on the iliacus, and very frequently it is clear of these and is found in the pelvis. These positions, varying as they do to such a great extent, are, nevertheless, found without evidences of abdominal disease. Moreover, it must be borne in mind that the walls of the cecum are thinner than those of any other portion of the large intestine. These variations are present at birth or take place shortly after and therefore a good proportion of our patients are predisposed to serious affections which errors in diet or daily habit may at any time precipitate.

Sometimes the axial rotation of the intestinal tract is arrested and the cecum fails to descend or only descends part way. The ascending colon therefore is capable of great variation in length. This variation is given by Cohan as from 10 to 29

cm. with an average length according to Treves of 20 cm. Occasionally it is out of all proportion to the size of the abdominal cavity.

The descending colon is the portion which is least liable to variation. It and the duodenum are the only parts of the intestinal tract that retain their original positions in the great primary vertical loop. On the other hand, the transverse colon varies much not only in its length but in its position as well. In the adult it has on the average a length of 50 cm. with a variation from 30 to 82 cm. It arches from the hepatic to the splenic flexure, which occupies not only a higher but a deeper position as well. With the patient lying down it is more frequently to be found above a line drawn from the highest point on one iliac crest to a corresponding point upon the opposite side. Possibly the transverse colon is below this line in one-fourth of all cases.

But great bends downward in the transverse colon in the forms of U's or V's are very common and these great deviations, which were first pointed out by Bright, are especially interesting to us. Generally in these conditions the transverse colon will be found bound down by adhesions, and they are potent causes of intestinal stasis. Decided kinks at the flexures have to be reckoned with occasionally and what is known as the "double-barreled stenosis" may exist at either flexure. Many of these bends are no doubt congenital and may be observed in the fetus or in a young child, but the greater part we believe are due to fecal stasis with concomitant causes such as tight lacing, faulty positions in standing, lax belly walls following confinement, and a passive lengthening of the mesentery from a sudden loss of fat.

Notwithstanding these anatomical considerations, which have long been studied in detail for the whole length of the intestine, a number of writers have lately advanced the thought that enteroptosis has a congenital basis as quite an original proposition. While radiograms taken after a bismuth meal are showing us that marked prolapse of the stomach and intestine is very common, especially in women, it does not necessarily follow that these deviations from the normal are accompanied by symptoms. We have seen several patients who exhibited enteroptosis to a marked degree, the greater part of the stomach and transverse colon being in the pelvis, but in whom abdominal symptoms were lacking.

Our conception of diseased conditions can only be founded on a careful and complete study of the parts affected in health. It is therefore evident that the surgeon who opens the abdomen with the determination of doing some general plumbing and of making the large bowel conform with some textbook illustration which he has in mind, is capable of much damage. He reaches the superlative degree of meddlesome surgery.

Constipation is such a common complaint that it becomes most necessary to examine this symptom carefully, both from the standpoint of cause and effect, before linking it to any anatomic condition which may be found to be present. It must be re-

membered that in some instances the widest departures from the normal are unattended by habitual constipation. This is just as true as the fact that some people of a most constipated habit are apparently in normal health and do not suffer from autointoxication. We recall a brassworker who had not had a bowel movement for sixteen days and complained only of abdominal discomfort resulting from carrying such a heavy load.

The time at our disposal does not allow a consideration of the indications for operation in such conditions as have been described. This is an engrossing but a lengthy chapter for the differential diagnosis, guided by physical signs and X-ray findings, is difficult and the surgeon must revert continually to his past experience in such conditions. It is hardly necessary to state that operation is only to be resorted to after all medical means have failed.

Having obtained a fair mental picture of the position of the viscera, and the condition of the large intestine in particular, we must carefully weigh the bearing which faulty position has on the symptomatology of the case in hand. If the transverse colon exhibits dilatation and a large bend downward, what will be the effect of straightening it? Possibly there will be no beneficent result if we have overlooked other conditions which may be present from the cecum to the rectum. The finding of all causes through five feet of large bowel is no easy matter and when one has operated on a few cases he will be very careful to collect all the information that is possible before subjecting his patient to such an ordeal.

Our own experience makes us feel that the first and most important operative feature that the surgeon must learn is a quick and easy manner of separating the dense adhesions which he meets in these conditions. They will be found binding down the large bowel tightly and forming kinks and angulations past which it is difficult for the fecal matter to force a passage. The bowel will generally expand at once when these are cut. Occasionally the adhesions are so dense that it is impossible to free the bowel and one must resort to anastomosis in order to make a proper passage for the fecal content, a method which while sometimes necessary, we consider in general poor practice. The raw edges left by cutting adhesions should be covered in wherever possible with No. 00 catgut on a fine needle. An intestinal stasis, severe and continued, will result sooner or later in a pericolitis and the formation of these adhesions. The surgical treatment of general ptosis is far beyond the limits of these remarks.

The thin veil-like adhesions which Jackson has excellently described and classified as membranous pericolitis are of a very different type. They are fairly common and Jackson's article must have recalled to the minds of many that they had dealt in the past with this condition, classifying it generally as light adhesions about the ascending colon with no further thought of their possible bearing upon the case in hand. A large number of observers, among them Gerster, Pilcher, Charles Mayo, Connell, Rubitshek, Lane, Crossen, and

Duval, have testified to this condition; Virchow mentions it, and Binnie gave a good description of it in 1905. Concerning the etiology, however, there are divergent views. Lane believes that the membrane is the result of the tendency of the cecum and ascending colon to fall, due to the upright position; that these lines of strain are crystallized into adhesions which forming bands tend to maintain the positions of these structures by fixing them to the abdominal wall. Charles Mayo is of the opinion that this membrane is due to the late rotation of the bowel and descent of the cecum, the cecum burrowing its way through the peritoneum. It is difficult to see how such a view is tenable. The membrane does not cover the ascending colon as do the layers of a hernial sac, and what is more, if Mayo's explanation is true, the cecum would be covered by this thin membrane, and this is not always the case. As Connell says, "Such an explanation attributes to the cecum in its descent from the liver the rather unusual choice of the route of the greatest, instead of the least, resistance, and prompts the question, Why burrow behind an already formed posterior parietal peritoneum, when it would be much easier to descend in front of this structure in the usual manner?"

We have regarded this condition as the result of a chronic colitis. These films are found primarily on the cecum and ascending colon; they have been reported on the descending colon as well.* Gerster is of the opinion that whether these veils are divided or excised they invariably return if the colitis persists. Many a surgical patient's enforced rest in bed and dietary regulation has brought a chronic colitis far on toward recovery. It must be remembered that the cecum is the widest and thinnest portion of the intestinal canal, that it is the seat of a most variegated bacterial flora and that the other conditions which have been enumerated make it splendid soil for the implantation of a catarrhal inflammation. In these respects the ascending colon is only second to the cecum. In one instance we have seen these thin, veil-like adhesions well marked on the ascending colon but becoming thicker and tougher as the region of the cecum was approached. The literature of pericolic abscesses, etc., in this region is growing rapidly and tends but to increase the role which a beginning mucus colitis plays in these affections.

Discussion.

Dr. Ryfkogel: I think that everyone will agree with Dr. Russ that in the vast majority of cases, constipation is a purely medical problem, but surgery can undoubtedly help many cases a great deal. Constipation is frequently caused by adhesions between the ascending colon and the transverse colon. I would like to disagree with Dr. Russ' statement that the so-called Jackson's membrane is purely an

inflammatory one. The impression is certainly given one that Lane is correct and that there is an effort on the part of nature to form a new mesentery. The Jackson membranes that I have seen were present in cases in which the ascending colon had more or less of a tendency to prolapse, and the appearance was always as if nature was making an additional effort to support the ascending colon. This curious membrane does not spread over on to the transverse colon, but is usually confined to the anterior portion of the colon and runs to the abdominal wall. The dissection off of this membrane has relieved symptoms, not only of constipation, but formation of large amounts of gas, and I always felt that this relief was due to the fact that the ascending colon was caused to adhere to the abdominal wall. Dr. Russ did not take up the matter of the Lane operation, which, of course, is very frequently done now—too frequently. I have opened the abdomen with the idea of doing this, but nearly always found something else that seemed to be at fault, either adhesions between the transverse and ascending colon, or some very marked prolapse with kinking, or strictures from old ulcerations, the correction of which put the patients in such shape that the subsequent medical treatment carried them on very nicely.

Dr. Levison: I was very much pleased with Dr. Russ' scholarly presentation of this subject. Here are two concrete examples of treating these forms of constipation—one I operated to-day. The diagnosis was made as preliminary to operation, and operation was carried out as expected. Patient had suffered for 20 years from habitual constipation. By means of the X-ray we could locate the apparent point of obstruction. His abdomen was opened to-day, and a kink attaching the colon to the thin edge of the liver was discovered, a number of adhesions were severed and tied off. The point of importance is the introduction of a long rectal tube high up in the intestine, which facilitates the evacuation of the bowels. Second—the same condition in splenic flexure, located by the X-ray. There were very firm adhesions, producing decided kinking. These were separated, and the man who had had almost complete bowel obstruction, was relieved and condition is satisfactory.

Dr. Lartigau: I would like to say a few words on constipation from the standpoint of the gynecologist. The subject is one of lively interest because women are frequent victims of this complaint. From this standpoint we will have to consider the obstinate cases of constipation from sagging of the whole large gut, in other words, ptosis. I would like to emphasize the point that while ptosis is a matter of importance, one has to be guarded in dwelling too much upon the mechanical factors of this subject. While operations have been advised for this condition, it has been my experience in watching such patients that 6 months or a year or two years after the operation they are as bad as at first. I have had two operated by Lane, the latter with marked improvement immediately following the operation, before which she had only one movement a week, accomplished by the use of different strong cathartics. After the operation the patient had normal bowel movements. But the condition gradually returned, and at the end of six months she was as badly off as at first. I would like to mention the psychological factor, which is not to be neglected. These patients have been treated from the psychical standpoint and cured. Some think that these cases must be studied with reference to perineal tears and to the sagging uterus. If the tear is bad, and there is marked sagging of the uterus, you will have to begin by repairing the peritoneum so that the sagging cannot occur.

Dr. Freytag: I think the X-ray is of extreme importance in diagnosing intestinal conditions. In cases of ptosis the great masses of bismuth meal

* Since the above was written Flint has published (Johns Hopkins Hospital Bulletin, Oct., '12) the fact that he has found these membranes in embryos and infants at term. He believes them to be normal structures and not inflammatory in origin. He acknowledges, however, that these veils may become somewhat thickened as the result of a chronic colitis. Flint states that his argument must be admitted "unless we accept the unproven theory of foetal peritonitis." It is interesting to know that this possibility has been advanced by Virchow, Treves, Simpson and Shober. It seems to us that many bands and adhesions have their beginnings in utero and are in character inflammatory.

fill the large intestine going down, although going up it will be nearly empty. As soon as the splenic flexure has been overcome, you see the big mass going down to the rectum. It has been said that ptosis sometimes causes no trouble, but if there is no trouble they have no reason to go to a doctor for examination. I think I can say that in the examination of the intestine we are very proud of our accomplishments.

FEEDING IN LATER INFANCY.*

By H. H. YERINGTON, M. D., San Francisco.

During the past six or eight years, probably no subject in medicine has received more attention than infant feeding, and with numerous schools advocating so many various methods, the family physician, if he tries to keep up with the literature, finds himself in a hopeless tangle.

Owing to the mildness of our climate here, the mortality of infants during the first year of life is not great, and even the artificially fed, are brought through this period with few upsets and begin their second year in fairly good condition.

The majority of people have the idea nowadays that a child if watched carefully during the first year, having its formula increased by the family physician, say, once a month, needs no further attention. Thus, the physician sees no more of the baby after the 12th month and the feeding is left to the mother, grand-mother and numerous friends, who have had great experience in bringing up their own children. This is partly the fault of the physician, for how many men can sit down and write out a dietary for a mother with proper intervals of feeding, for a child during the second and third year of life? It is a common opinion that if a child goes through its first year without any signs of rickets, the danger of this disease is past, but this, unfortunately, is not true, because often owing to careless methods of feeding, beginning with weaning and lasting through the second year, marked rickets may be the result.

In the Children's Clinic of the Medical Department of Stanford University, it is our custom to begin adding substitutes for milk at about the 11th and 12th months, and either a small feeding book or a carefully written dietary is given the mother, with directions as to the intervals of feeding and amount of food to be taken. At this period, when a change of food is begun, it is important to watch carefully the ability of the child to digest its new food, and this necessitates an examination of the stools at various times, which is a simple procedure, and can easily be done by any one.

Briefly, the examination includes three parts:

1. Macroscopic, including size, color, consistency, odor, mucus, pus, blood, food masses, parasites, etc.
2. Reaction to litmus.
3. Microscopic examination, including—
 - a. meat and vegetable fibres.
 - b. a Lugal stain for starch.
 - c. Soudan red and acetic acid stain for fats, fatty acids and soaps.
 - d. stains for bacteria, such as tubercle, colon bacillus, etc.
 - e. parasites and ova.

Such an examination can easily be done in fifteen minutes, and in any intestinal condition should never be omitted.

During childhood milk should be the basis of diet, and the rule of giving not more than 24 oz. in 24 hours is a good one. Small children getting a quart or a quart and a half of milk a day, often suffer with flatulence, colic, and constipation and, as a rule, refuse other food. A normal baby, age 12 months, weighing, say 21 lbs., should have not more than five, and better, four feedings a day. An ounce of orange juice diluted with water should be given on waking in the morning, at least a half hour before milk is given. The subsequent feeds should be given at 7:30 a. m., noon, 3:30 p. m., and 6:30 p. m. At first a ten o'clock bottle may be given, but this can soon be eliminated because with a liberal meal at 6:30, the child will sleep until the next morning. Varieties such as well-cooked cereals, zweiback or toast, scraped beef, or beef juice, some well-cooked vegetables in the form of purees, part of a baked potato, baked apple, apple sauce along with five or six oz. of milk at a feeding, should be the dietary from the 12th to the 18th month.

Many mothers come to you during the child's second year, saying that their child will not take milk, and this is due to the fact that after the 12th month, so much fresh bread, sweets of all kinds, etc., are given and the children are fed so often between meals that their desire for milk is lost, and they prefer substitutes instead.

During the latter part of the second year, and through the third year, children should take not more than a pint and a half of milk during the day, and the mother should arrange the time of meals at intervals to suit the household, the point being that the feeding periods be regular and the time between meals increased. If this rule be adhered to, the child will have an appetite at meal time, and the so-called "intestinal indigestion" will be warded off. Such foods as finely cut meat,—beef, mutton, steaks or chops,—can be added, with soft boiled or poached eggs, custards, gelatine jellies, etc.

I would say that the two most common causes of intestinal disturbances in young children, are the over-feeding with fats and starch. Owing to the richness of our certified milk, we find children with flatulence, constipation, loss of appetite, eczema, and restlessness, whose condition clears up

*Read before the Medical Section of the San Francisco County Medical Society, June 4th, 1912.

on a skimmed milk diet. On the other hand, we have a class of cases we call the "starch" type; very pale, showing blue rings under the eyes, having abdominal pain and often an enuresis.

On examination of the stools, we find a quantity of undigested starch granules, and a report of the dietary shows the child has been living on cereals, milk, and a considerable amount of fresh bread and cake between meals. In the majority of these cases a proper non-starch diet, with iron and gray powder, regulates the condition, and the improvement is rapid.

In conclusion, I would say that much of the intestinal disturbances in young children could be avoided if the family physician would give the mothers definite rules in writing as to proper food, and definite intervals of feeding.

DIETETICS FROM A MODERN STAND-POINT.*

By ANNIE W. WILLIAMS, M. D., Hayward.

In this age of searching analysis keen observation, thorough research, extensive and exhaustive laboratory experiments, practical demonstrations and laborious investigations, dietetics, the science or study and regulation of the diet, has not been overlooked, but has received its full and much needed share of attention. World-wide questioning is being directed to the disquieting fact that eating just for self-gratification, the good taste and flavor, because you happen to like it, and to satisfy a pampered, over-cultivated and oftentimes more or less perverted appetite, is possibly not all it should be.

We, the members of the medical profession, are many of us overlooking and disregarding some very vital facts concerning diet. Not the diet of the few but the diet of to-day civilization. Twentieth century scientists have painstakingly compiled for our consideration a reliable array of valuable facts that can be immediately adopted for practical use in every-day prescribing.

Dietetics considered from a modern standpoint not only takes into account the food units, food values and nutritive values of foodstuffs but also considers their medicinal values, which furnishes a fascinating field of study and research. In the near future the medical profession will be able to compute not only the nutriment values, the nourishing and sustaining values of the diets that they are prescribing but also just what medicinal values, if any, with the estimated dosage.

Take the yolk of an egg, for instance; it is a most perfect natural emulsion containing in solution or suspension several important and well-known drugs which physicians are daily prescribing. Iron, which has heretofore been supplied to the medical profession from the mineral kingdom, is now being prescribed in some cases by giving the patient the vegetables in which iron is found. The iron as contained in the vegetable is in such

a form that it is readily assimilated by the human system and without any of the disturbing effects often following the administration of metallic iron.

Modern dietetics admonish us that the juice of lemons is to be preferred to vinegar and that the sub-acid fruits are very helpful to a certain class of patients. We are enjoined not to let a day pass without eating something in the way of raw food and are informed that honey is a storehouse of energy and a natural laxative.

In the way of raw foods may be mentioned: a stalk of celery, a crisp young carrot, fresh lettuce, a quickly grown white turnip, a crisp cucumber, mild, sweet, green onions, and other raw foods too numerous to mention. The amount of painstaking scientific investigation and research that has been accomplished and published along the lines of foods, food values and nutritive values of foodstuffs is truly amazing to the uninformed mind upon this particular phase of diet. Stokes & Co. of New York make a specialty of publishing and supplying a goodly number of publications including the more recent up-to-date works upon this subject.

At all the world's great seats of learning and universities and research laboratories much time, expense, labor and laboratory space has been devoted to the scientific study and searching investigation of food materials and food stuffs, including practical demonstrations on human squads, and the man in the box, and other exhaustive experiments; which on the whole have furnished more or less satisfactory enlightenment upon this subject. The sum total of knowledge thus acquired, and sifted out, being of undoubted scientific and practical value.

In my last trip across the continent I noted that all our American universities are taking a most prominent part in these nutritive investigations. Our own state university is very much up-to-date in this line of work and most valuable information and data may be obtained from the professors and the investigators engaged in this work there. It has been stated by an eminent Russian investigator, Mr. Smolensky, that more has been accomplished in ten years in the United States than could have been done in Germany in fifty years.

In many public libraries books treating of these subjects are now to be found; notably in Berkeley public library, where the works of some of the most noted writers upon these subjects are to be found on the shelves. The modern physicians who desire to be well equipped and not out-of-date will realize the deep importance of informing themselves upon these modern phases of dietetics which are making such rapid advances and remarkable strides forward.

It makes one rub one's eyes to learn that those severe twinges and dull aches in the shoulder muscles which have been duly scheduled under the convenient and all-inclusive name of rheumatism, may be due instead to a parasite that we take into our system with the pork that we find so delicious and satisfying. It has been discovered, and even depicted upon moving picture

*Read before the Forty-Second Annual Meeting of the State Society, Del Monte, April, 1912.

screens, that these parasites choose as their favorite habitat in the human body the shoulder muscles, where they locate and become domesticated. This is to be thought of the next time your patient bitterly complains of persistent so-called rheumatic pains in the region of the shoulder which the customary treatment and usual medicines have failed to relieve.

Then there is the caffeine to be considered which we so innocently imbibe in our favorite table beverages. It is being strongly urged that its continuous, continued use will set up a train of ailments which if persisted in will in some cases become threatening and serious. When one is warned by an incipient insomnia or an interference with digestion the best plan would be to discontinue these customary table beverages at once.

Alcohol has lost its prestige and is being tabooed to its place among the other well-known narcotic poisons, by the findings of science, by all well-informed physicians and by all those who have been properly instructed in regard to the scientifically proven narcotic action of alcohol.

The subject of modern dietetics is becoming of such definite and decided interest to the universal, general public and to humanity in general, that the leading magazines and papers are devoting valuable space with most prominent headlines to the subject. For instance, *The London Lancet* gives emphasis to the fact that port wine contains tannin and is thus unsuited to many constitutions and that walnuts besides containing 63 per cent. fat and nearly 13 per cent. of protein also contain tannins and thus disagree with some constitutions.

These instances might be multiplied and they serve to prove the world-wide universal interest in the public mind; that is being shown in modern dietetics, the wide-reaching scope of that interest, and the intelligent nature of it. Formerly we demanded that our food should appeal to us. At the present time we are not quite so well satisfied unless it also furnishes us with an all-around nourishing sustenance.

We have been demanding in a rather telling way that our flour should make pretty and attractive loaves of bread, and consequently the wheat kernel was necessarily divested of some of its vital nourishment, that it might furnish a whiter shade of flour. Another almost naturally perfect, wholesome article of diet, rice, had to undergo polishing to render it more attractive in appearance. This process of polishing robbed the rice of its proteid constituent. In the modern diet unpolished rice is returning to favor and many of us have learned to purchase the unpolished rice exclusively. Very fortunately the potato, another almost perfect all-around article of diet, with its peeling as a protective coat escaped the beautifying treatment and reached our tables in its natural state. Most of us in eating this delicious tuber and prime favorite of the vegetable kingdom, add a little butter and this addition makes up for the fatty constituent in which the potato is normally lacking.

A sweeping edict of modern dietetics has doomed the frying pan, that universal favorite utensil of the culinary art. No longer need housewives fry themselves as well as the viands, in order to appease the hungry members of their household.

This is an age of modernity, individuality, and individual thinking. Established customs and usages no longer hold an unquestioned grip on things universal. The why and wherefore are being sought, individually and collectively, and most eagerly sought. The world has turned the searchlight of rigid investigation upon the subject of food and food effects and the resultant conditions. Health and diet have become a topic of paramount importance. Modern dietetics takes note of the undeniable truth contained in that terse but illuminating passage, "Man does not live by bread alone." It recognizes the fact that mankind is a creature of complexity, composed of physical, mental and spiritual factors so intimately intertwined and interwoven as to produce more or less of a failure whenever any of his triune faculties are overlooked or neglected.

No matter how exact and scientifically correct the prescribed diet may be, to obtain the desired results which above everything else is what both the physician and patient are seeking, all these contributing and ameliorating conditions must be taken into account. Mankind when created was placed in the all-pervading fresh air, the dome of the sky with all the glories of its diurnal changes above him, the earth with its interchanging seasons beneath his feet and the beauties of nature all about him.

In his strenuous endeavor to improve conditions mankind built four walls. At first the walls were mere skeletons and not four in number but presently they were increased to four forming a complete enclosure and gradually becoming stronger, firmer and thicker, until it became necessary to break holes in them to admit the air. In the progress of events doors and then windows were devised and as a crowning achievement panes of glass were made and fitted into the windows. The windows were tightly battened and the doors locked and at last mankind was securely shut away from his natural and intended environment. He complacently set himself down and endeavored to bring up his progeny under these alien and unnatural conditions. The fresh air could not reach them except in scant supply, the sun was prevented from shining upon them, the blue of the heavens with all the splendors of the sun, moon and stars, clouds, fogs and mists, was roofed out from them, their feet were carefully shod and faithfully kept from treading mother earth and all the beauties of nature were mostly shut out from their view.

Many unknown and unheard-of diseases became fastened upon mankind, all of which are classed under the head of the so-called house-diseases, notable among which are dyspepsia and tuberculosis or the white plague. Results have unmistakably proven that house life versus out-door life is a disastrous failure and that mankind has deteriorated markedly.

Mankind is evolving from the period of searching experiment and rigid investigation as to the effects of feeding and housing upon domestic animals into the period of similar searching and rigid examination as to the effects of feeding and housing upon the human and is obtaining the same successful and satisfactory results. The fact has dawned upon mankind that they have made some egregious blunders in their endeavor to improve upon normal mundane conditions and now the word has gone forth, uttered with an insistent meaning, "Back to the great outdoors" and mother earth and natural modes of living.

In a recent lecture on the "American Mind" the noted speaker said, "intellectually the American is inclined to radical views, but he has a great deal of practical conservatism. There is in fact conservatism in our blood and radicalism in our brains, and now one and now the other rules."

In this question of dietetics one need not be too radical or unduly conservative but rather choose a middle course and adapt the diet to the individual need. We are not compelled to follow the most radical and live exclusively upon raw foods though they are of undoubted merit and deserving of careful consideration, or is it necessary to confine the diet to just one article, although this is helpful to some cases for a certain time. Neither need we be so very conservative as to refuse to accept the findings of science as regards these nutritive investigations, as to the most desirable diet for health, efficiency and endurance.

The fact of the matter is, mankind the world over is not only accepting the teachings of science on dietetics as rapidly as they can readily assimilate them, but they are eagerly seeking out for themselves all the facts and information that is attainable. They evidently agree with Emerson who says, "Get health, no labor, pains nor exercise that can gain it must be grudged."

In closing this paper may I urge upon the medical profession as a whole that they give their most earnest thought and careful attention to this more recent modern phase of the subject of dietetics.

Discussion.

Dr. D'Arcy Power, San Francisco: I am sorry that the subject of dietetics has not been more fully represented in the program of this meeting. There are many points on which we are still partially informed and among these one of the most recently brought forward is the fact that there is not a strict relation between caloric values and nutritive values. That is to say, there are foods having the same caloric values which when applied to actual feeding of live stock give very different results in the actual nutrition of the animals fed thereon. Furthermore, I have a strong belief that some of our constants are not always reliable. Thus it is usually assumed that a calory diet of less than 1500 calories per day must necessarily be insufficient to maintain equilibrium, but personal observation convinces me that there are abnormal people who maintain their weight on a dietary of smaller calory value than this. Lastly I would like to point out that Dr. Williams' remarks about coffee are not borne out by recent experimentation as it has been shown that coffee is capable of stimulating and improving

both mental and physical work without a negative phase.

Dr. Annie W. Williams: I consider that the difference between my statement in regard to the use of caffeine and that of Dr. Powers, who so kindly and ably discussed my paper, lies in the fact that the statement I make in the paper refers to the continued, continuous use of caffeine for not only days and weeks but for months and months and years and years in our table beverages. Dr. Powers' statement I believe would refer more particularly to its drug effect as a tonic drug. I will now close the discussion, thanking you for the manifest interest and attention accorded to my paper.

A RECENT CASE OF LIPECTOMY.*

By H. EDWARD CASTLE, M. D., San Francisco.

In presenting this case I am showing you not an unusual form of deformity. Truly it may be called a deformity when adipose tissue increases in a localized area to such an extent that the body is so ill proportioned. The treatment I shall mention, while not entirely rare, is far less common than it should be. With the beneficial results I have obtained with lipectomy I feel this statement is not too dogmatic.

The lady, a private patient, has been so kind in permitting herself to be photographed and other



Figure I

publicity would be so embarrassing I felt it improper to ask her to come before you this evening, therefore I shall present the case by lantern slide demonstration which I feel will depict her condition before and after operation to your entire satisfaction.

*Presented before the Surgical Section of the San Francisco County Medical Society, June 18, 1912.

The patient was forty-two years old, five feet two and one-half inches in height, and weighed two hundred and sixty-five pounds (Figs. I and II). Her mother weighs two hundred pounds, and has myocarditis. Father weighs two hundred and ten pounds. One sister is fleshy but not overweight. Otherwise her family history

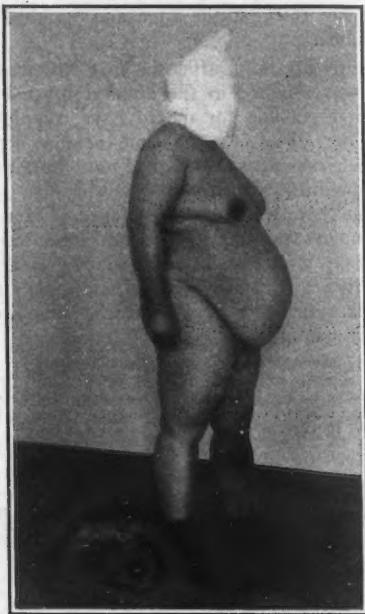


Figure II

is negative. She has eight children, the youngest is two years old. Since the birth of the youngest child there has been a marked distasis recti abdominis and a large umbilical hernia. Three years ago varicosities of the left leg began in the internal saphenous and its tributaries. A year later a similar condition was manifest in the right leg. Two weeks prior to operation a large hematoma developed on the inner side of the left leg about four inches below the knee. Under general anesthesia the left leg was operated after the Trendelenburg-Ferguson method, the right leg after the Trendelenburg-Schede method. The large pendulous abdominal adiposity was removed by Kelly's method of lipectomy and the umbilical hernia taken care of by the ingenious method of Mayo.

It is my desire to draw your attention to the operation of lipectomy. Owing to its extreme simplicity and undoubted benefit I can conceive of no reason why it is not more often done. True it is that any infection introduced into a wound so extensive as this might play havoc, but this must be taken for an excuse for improper work rather than against the performance of the operation. Owing to the great weight of the patient and the incision extending far in the back it takes

extra care to avoid contaminating the ends of the wound.

Beginning the incision two inches lateral to the spinous process of the first lumbar vertebra it is carried across the abdomen above the umbilicus to an analogous point on the opposite side; the ends of this incision are joined by a second one traversing the abdominal wall above the pubis, thus marking an ellipse. The flap on either side is dissected back one inch, thus permitting a better closure of the wound. This incision is now carried down to the deep fascia and the elliptical piece is rapidly removed by the use of a knife about eight inches in length. Care must be exercised as one approaches the umbilicus, as here the superficial fascia is nearly lacking and one might readily open the abdomen. The field is covered with towels wrung out of hot salt solution while the umbilical hernia is repaired. In closing the wound three sets of sutures are used, viz: a row of silkworm tension-sutures are placed one and one-half inches from the edge of the flap, passing in through the integument and superficial fascia, picking up the deep fascia and out through the other flap in a corresponding position. These sutures are placed about two inches apart. As they are introduced each end has a hemostat placed on it. The superficial fascia is closed by a continuous catgut suture and the skin by a continuous horsehair suture.



Figure III

The utmost care should be exercised in making an exact apposition of the edges of the skin as this is of paramount importance in rapid and primary wound healing. After the horsehair suture is placed each silkworm gut suture is run through a small rubber tube, which is about two inches in length, and tied. The object of the tubing is

to prevent the silkworm gut from burying itself in the skin, at the same time permitting the inspection of the wound, which cannot be obtained



Figure IV

if the sutures are tied over a bolster of gauze. There is no occasion to employ drainage in these cases, and I object to its use, as I do in all clean



Figure V

wounds. I do advise, however, a daily inspection of the wound and the introduction of a grooved director between stitches if there be any accumula-

tion of serum present. A moderately snug abdominal bandage is applied over the dressing and the patient put to bed on a back rest so as to slightly flex the body.

Fig. 3 shows the insulating tubes five days after operation. Fig. 4 shows the patient two weeks after operation. Fig. 5 represents the shape of the specimen as removed. It was one yard and three inches long, one foot and a half wide, three inches thick at the edge and weighed seventeen pounds.

Although up daily, after the first two weeks, the patient was retained in the hospital for five weeks to make it possible for me to have complete control of her diet. At the time of her departure from the hospital she weighed one hundred and ninety pounds, which was seventy-five pounds less than her weight on entrance. Her waist measurement was eighteen inches less. She will be kept on a diet, which is reducing her at the rate of two and a half to three and a half pounds per week, until her weight reaches one hundred and forty pounds.

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REPORT OF CASE OF DOUBLE TUBAL PREGNANCY.

By DAVID HADDEN, M. D., Oakland.

I want to report in this paper a case of double tubal pregnancy and a case of hemato-salpinx with bleeding into the peritoneal cavity unassociated with pregnancy.

The first patient, a woman of 35, has been married five years, but so far has not been pregnant. The history previous to the present sickness gives nothing of value except that a year before marriage there was an acute attack of pelvic trouble lasting some weeks, the main symptoms being pain in the pelvis and fever. The woman up to the time of that attack had been in good health, since then has had more or less trouble with her periods and is on the whole rather run down, but with no symptoms of any definite type.

I saw the patient first after a diagnosis of tubal pregnancy had been made by the attending physician. She was then two weeks over her menstrual time, which was by no means unusual for her, the only difference being that she was more nervous than usual and somewhat inclined to hysterical attacks. She complained that the breasts had been a shade sorer than usual, but that was only relative, as she had always more or less soreness at the periods.

On the evening of June 19th the patient began to have a brownish discharge gradually getting more profuse. About midnight while at toilet a sharp tearing pain occurred in the right side with a feeling of faintness. From then until the following noon the pain was quite persistent being mostly in the lower right side of the abdomen and was accompanied by diarrhea and nausea. When these symptoms subsided the patient felt comparatively well except for the extreme tenderness over the lower abdomen.

Examination showed the breasts somewhat tender but not enlarged, Montgomery tubercles more marked than normal, but patient says they have

always been so, otherwise the breasts gave no suggestion of pregnancy.

Abdominal palpation gave tenderness over both inguinal regions with a greater rigidity on the left side. Pelvic examination showed a uterus somewhat enlarged, cervix soft, considerable enlargement of right tube with extreme tenderness. A soft boggy mass occupying the left broad ligament and only slightly tender to touch. A grumous discharge from uterus. A diagnosis of an intraligamentary ruptured tubal pregnancy on the left side with probably a hydrosalpinx on the right was made.

The operation showed the left broad ligament distended with blood from a ruptured hemato-salpinx. On the right side a hemato-salpinx (unruptured) which at the time was considered to be a sympathetic condition or perhaps similar to the other case reported in these notes. The microscopical examination of the right tube showed, however, the presence of villi and though the examination of the left tube has so far not been made carefully, I feel justified in diagnosing the condition on that side as an intraligamentary rupture of a tubo-ovarian pregnancy. I know of no condition which would cause a hemorrhagic rupture unassociated with weakening of the tubal wall as occurs from the villi penetration.

The second case is one of a woman, 29 years of age, who up to the time of the attack here reported had been in good physical condition with nothing of value in the history except that she was married some time ago, but for some years has not been living with the husband. The attack commenced as an acute pelvic inflammation, the gross pathology presenting in the left tube.

A diagnosis was made of pyosalpinx, which was confirmed by another gynecologist, who kindly saw her for me while I was on a vacation. Expectant treatment was adopted and the pain, temperature and soreness gradually subsided, the left tube remaining enlarged. There had been no disturbance of menstruation and no symptoms pointing to a tubal pregnancy. Some two or three weeks after the onset of the trouble the patient was up, feeling fairly well and anxious to return to work.

Without permission she took a street car ride and returned home suffering intense pain in the left side. Locally the findings were unchanged for some days, but the temperature returned and the patient was generally in poor condition. This happened while I was out of town and on my return some days later I found on pelvic examination a large mass projecting in the cul de sac and made a diagnosis of pelvic abscess.

A posterior incision showed a large collection of clotted blood. The left tube much distended, high up and adherent. After the operation the patient's condition improved markedly, but fresh bleeding continued through the gauze packing. Twelve hours later a laparotomy was done and a large oozing hemato-salpinx was removed from the left side. The recovery was uneventful, drainage being continued from the cul de sac.

No question as to the condition was raised in either the consultant's or my mind until some time later when the patient denied absolutely, the possibility of a pregnancy being present. A careful microscopical examination of the tube made then showed no embryonic structures and the man who made the sections reported that it reminded him of a similar case of a nurse at Johns Hopkins where an exceedingly thorough examination showed no signs of pregnancy.

Oakland (NOT Santa Cruz) is the place of the Annual Meeting of the State Society, April 15, 16 and 17, 1913.

THE TECHNIC OF THE REMOVAL OF FOREIGN BODIES AND NEW GROWTHS FROM THE ESOPHAGUS.*

By W. P. MILLSPAUGH, M. D., Los Angeles.

This subject is a little bulky for a ten-minute paper and I shall begin immediately to use the pruning shears. That portion of it referring to new growths is an unknown field to me, and I shall leave it untouched. Malignant growths are almost the only ones found in the esophagus; their removal belongs to general surgery.

In discussing the removal of foreign bodies, I suppose some mention should be made of the older and well-known methods. But I shall give very little time to this part of the subject, for I believe that those older methods are so blind and uncertain and dangerous that they should be discarded in practically every case where esophagoscopy is available. The number of men employing esophagoscopy is increasing rapidly, so that in the near future this means of relief will be available in nearly all parts of the country. And while time is very important in these cases, it will frequently mean less danger to the patient to take the time necessary to reach an esophagoscopist than to try to remove the foreign body by the old means.

Among the old methods I shall speak of inversion, the induction of vomiting, the administration of more or less solid food; the use of the bougie, probang and coin-catcher; and of the esophageal forceps.

I suppose it does a child little harm to stand him on his head and try to shake out a swallowed foreign body, if that effort is not persisted in too long. And if the body is round and smooth I suppose it would do little harm to give emetics and thus try to eject the intruder. And, further, if it be known that the body is not only smooth but of such diameters that it could be forced into the stomach without great risk it would sometimes be permissible to administer solid food, in an effort to carry it along, or even to carefully push it along with a bougie. No doubt these old methods have frequently been crowned with success, and in certain cases are relatively free from danger. It is astonishing what the esophagus will sometimes tolerate, as well as the rest of the alimentary tract.

The probang and coin-catcher are ingenious devices, frequently successful in proper cases, but responsible also for much hidden and disastrous damage; they belong to a chapter in surgical history which should be closed. The same praise and the same condemnation belong to the esophageal forceps; by these I mean the curved or angled or flexible forceps which are introduced blindly and which bite blindly for their object. Who could know whether the resistance felt on withdrawing a body by such forceps was the resistance of the body against the esophageal wall or whether a portion of the wall itself was coming, and how could one tell whether the point or edge of a sharp body were perforating or lacerating the wall in its passage? Of course the fluoroscope properly

* Read before the Los Angeles County Medical Association, November, 1912.

managed would be a great aid in the manipulation of these instruments.

In thus condemning these old and useful procedures as generally too dangerous, I do not by any means claim that esophagoscopy is free from danger. It has many dangers, which will be considered at length later; I have spent anxious hours over a patient after an attempt at esophagoscopy, not knowing at what moment his pulse and respiration might cease.

The technic of removing foreign bodies by esophagoscopy resolves itself into two main problems—the introduction of the tube to the level of the foreign body, and the grasping and withdrawal of the body.

The question of anesthesia has always to be settled. It differs somewhat from the similar question in bronchoscopy; here there is never any need to preserve the cough-reflex, and the greatest possible dulling of sensation is desirable. However, the esophagus itself is not very sensitive, and the tendency with most men in this field seems to be away from general anesthesia toward local anesthesia aided by the hypodermic use of morphine. Some work at times with no anesthesia, in very young children, for instance. Janeway and Green¹ have even done a large number of gastroscopies under the following routine anesthesia: 1/4 grain morphine is given hypodermically shortly before the examination; a little later 5 grains of anesthesin are given by mouth; finally the pharynx is thoroughly anesthetized with 10% cocaine. They state that "the degree of discomfort experienced has not been regretted by any of the patients examined." It is usually desirable to give from 1/150 to 1/100 grain of atropine with the morphine; this lessens the secretion of mucus, which is nearly always troublesome. In certain cases, notably in children and very nervous patients, general anesthesia will be necessary, especially if the foreign body is such that much manipulation will probably be required. In my judgment chloroform is too dangerous, and ether should always be used unless especially contra-indicated. Rectal or intravenous anesthesia would be very pleasant for the examiner, if only they were safe. The administration of warm ether vapor through nasal or mouth tubes would be of advantage. But ordinary anesthesia is satisfactory; the patient should be put well under before work is begun.

My own experience has been limited to the use of the Jackson instruments, and the position of the patient and other details of introduction into the esophagus are similar in many respects to those for introduction through the larynx. If local anesthesia is used the patient is usually seated on a low stool. An assistant sits behind him and steadies and supports the head. For general anesthesia, the patient lies supine, with shoulders extending four or five inches beyond the end of the table, the assistant seated at his right supporting the head and neck. Just lately I have begun the use of Jackson's direct laryngoscope. This may be introduced into the upper esophagus for a short distance, far enough at times to reach

the foreign body without a secondary tube. If the body lies lower, the esophagoscope may be introduced through the laryngoscope, past the troublesome cricoid, after which the laryngoscope may be withdrawn, leaving the longer tube in position. Johnston of Baltimore uses this method largely; to me it promises considerable satisfaction. The older method is to introduce the left index finger as far as possible toward the patient's cricoid and then slip the tip of the esophagoscope along the finger to one pyriform sinus; this point being reached, if the assistant secures just the right amount of forward stretching of the neck and of extension of the head on the occipito-atlantal joint the tube can be slipped into the esophagus quite readily. This sounds simple enough, but to me it has usually been the hardest part of the task; a trained assistant for holding the head is a most valuable asset. Once well past the cricoid the tube usually slips easily down the rest of the gullet, the assistant varying the position of the head and neck slightly to prevent undue pressure of the tip of the tube. In foreign-body work the tube should always be introduced without its mandrin and every centimeter of the esophagus inspected from above downward. Of course if the body is known to be low down the mandrin may be used in the upper part, but even in this case it is better to examine the whole length of the gullet, noting the amount of traumatism which the body has caused.

Having reached the foreign body, the second main problem is before one. Important points in this problem are the shape and size of the body and whether it is firmly embedded, whether it has sharp points or edges, perhaps already fixed in the wall or, if not, in such position that traction is likely to cause them to perforate. Pins, open safetypins, sharp pointed bones and similar dangerous objects are among those frequently swallowed. To remove these safely calls frequently for much judgment, care and ingenuity. Various clever instruments have been devised for closing safety pins, cutting pins, breaking tooth plates, etc. In general the principle is to try to draw the sharp points or edges into the tube before attempting to withdraw them, unless they happen to be pointed safely downward. When the body is too large to pass through the esophagoscope, tube, forceps and object must be withdrawn together, except where it is found possible and advisable to break the body into fragments.

We come back now to the danger of removing foreign bodies by esophagoscopy. It is to be remembered that we are working in a long tube with delicate walls, in close proximity to the pneumogastric nerve; and to enter this tube we must obliterate the angle which it forms with the cavities of the mouth and pharynx. As an aid to this and in the early days of esophagoscopy it was considered good form to pull out at least one upper incisor in order to make more room. This is no longer thought proper, but we are mighty glad when the patient happens to have lost them! There is danger of perforating the esophagus with the tube, but this should never

1. Janeway and Green. Surg. Syn. and Obst., Sept., 1911.

occur; force in inserting the instrument is unnecessary and utterly unjustifiable. There is danger of causing retro-pharyngeal abscess from traumatism; this has occurred at the hands of very good men. It should teach us to use the utmost gentleness and care. There is danger of laceration and perforation of the esophageal wall from misguided efforts to withdraw a sharp or angular body; the result may be mediastinal abscess and probable death. There is danger of reflex stoppage of respiration. I had such an experience in the case of a four year old girl who had a penny lodged in the esophagus. Just as I withdrew the penny and tube respiration ceased entirely; artificial respiration was necessary for several minutes before she breathed right again. This was under ether anesthesia. There is danger from the anesthesia itself. A nervous patient I wished to examine for suspected cardiospasm did not behave well under morphine and cocaine so ether was given. Manipulation had hardly begun when both heart and respiration went bad and, as I said above, hours passed during which I feared he would die on my office table. There is danger of edema of the glottis. Preparation for tracheotomy should be made and one able to do the operation should be at hand in nearly every case.

These are the chief dangers in this work. They seem formidable and they should lead us to use the utmost care. But we must remember that every patient with a foreign body lodged in the esophagus is already in danger. The question is: shall we ram something blindly down his throat and push the object down or pull it up or thrust it through the esophageal wall? Or shall we go after it in this other relatively safe and wholly logical manner?

PROPHYLACTIC MEASURES FOR PEOPLE GROWING BLIND IN LATER LIFE.

By S. HELLER, Director of the Institute for the Blind, Hohe Warte, Wien.

Translated by C. S. G. Nagel, M. D., President California Society for the Prevention of Blindness, San Francisco, Cal.

The interest in the blind awakened lately in various parts of the country would seem to justify the bringing more widely before laity and profession the following address delivered before the Vienna Ophthalmological Society, by S. Heller (Prophylaktische Massnahmen für später Erblindende, Zeitschrift für Augenheilkunde, January, 1911).

The policy and training advocated by the author appeals to one immediately as sound for suitable cases; on the other hand, we must not overlook the fact that the question involved (sc. of prospective blindness) is not always simple; in case of slow progress and where it is impossible to know whether we may not ultimately succeed in inhibiting the down grade progress, as in glaucoma, e. g., it must always be a matter of medical tact and judgment, whether to reveal the worst possible alternative of the issue to the patient. The matter is further complicated by constitutional temperament on the part of the patient. Still it remains quite true that the clinical viewpoint per se always inclines rather to concealment of blindness as an eventual outcome as sealing the patient's doom from a therapeutic standpoint, and it is highly meritorious on the author's part to put his pedagogic claim and raisonnement for an opposite prin-

ciple of meeting that fateful eventuality before the profession.

"To become blind in early or full manhood means to the sufferer not alone the vanishing of the outer world with its infinitely manifold effects of form, light and color, but also the exclusion from every regular vocation, loss of independence and deliverance into charitable care. This committal to a passive pseudo existence with all its anguish, is unjustifiable; it is brought about by the traditionally sentimental conception of blindness and its consequences, but is contrary to modern pedagogics for the blind (as based on psychology and elaborated technically), which offer the means to preserve to the blind full activity and restore to them the joy of living. Experience in a practice of thirty-seven years, and more especially the results of the institution founded by me in 1898 for the training of those grown blind in later life, have confirmed in me convictions which I crave the privilege to bring before you, coupling therewith a request by the granting of which you will be able to benefit humanity yet more than you have done heretofore.

"It is as much an irrefutable demand of humanity as a postulate of justice to have every one growing blind be brought under blind-pedagogic instruction unless unfitted therefor through physical or psychical disease. This undertaking must, however, on no account be deferred until blindness is complete, and even less permissible is it to let some time pass by unused after absolute blindness has set in, lest the important and most efficient points of attack for pedagogic measures be reduced considerably or qualitatively lowered or maybe lost entirely. The pathetic picture of petrification presented by so many blind is not, as so often believed, the necessary consequence of blindness, but rather that of omissions and neglects which cannot be sufficiently deplored. Activity and definite aim are important factors for the buoyancy of our being; if they are rendered inactive, if resignation and apathy take their place, the rise of an ever increasing stagnation follows naturally. The great task to restore to one growing blind with the faculty to work, an existence humanly worth while, makes the demand absolute, to begin this training already in the preliminary stages, or better still, as soon as the loss or a decided diminution of vision have been prognosticated by the physician.

"There are weighty reasons for such a procedure. Success of pedagogic influence upon the prospective blind would be quite illusory if one were to start with the premise that for the visual perceptions those of touch, or of touch-hearing, could simply be substituted, or that the connexion between the one and the other could be established by a mere mechanical juxtaposition or sequence. Nor are we indeed dealing here with a transmission per se, but rather with such a one that has assumed the character of permeation. The deterioration of vision causes the sufferer involuntarily to control and complement his deficient visual perceptions by touch. Through systematically and rationally training this process, which becomes gradually and successively a necessity, the qualities of vision as they had originated primarily through differentiation of the power of touch, gradually will transform themselves into those of touch and touch-hearing. Thus are formed specific psychical formations hardly definable, in which the problematical value of perceptions of touch is constantly and materially heightened by their new meaning. This process arouses a vivid interest in the prospective blind and the consciousness of a newly gained possession. Therefore, and because in the same proportion as vision diminishes the new acquisitions are augmented quantitatively and qualitatively heightened, this transmission becomes the compensation that is apt to mitigate in the most beneficent way the surpassingly painful contrast between seeing and non-seeing. These empirical facts have a bearing not

merely on the knowledge but also on the activities of the prospective blind.

"Transmission of the qualities specific to visual perceptions into those of touch has the effect of enabling one grown blind later in life to reproduce and retain the manifold pictures acquired before through the eye and stored in his memory and to make use of them for combinations. The omission, or even the mere postponement, of this important and effectual transmission often brings it about that the memory pictures grow increasingly dimmer and confused, that they are finally submerged and that painful state becomes permanent that we feel in passing when we are absolutely unable to remember a well-known name, a state quasi identical with a second psychical blindness and which leads not rarely to despair and desperate deeds.

"Unforgettable will be the impression I received when a young woman who some years after her complete blindness entered our institution, exclaimed in painful emotion, 'Just think, I cannot imagine any more what my mother looked like.'

"To begin the training of the prospective blind as long as they are still possessed of a certain degree of sight is also imperatively required with regard to any vocational work. In many cases it is the aim to not interrupt the old activities and to so guide the training that for every insufficiency or difficulty that may occur the prospective blind will use curative pedagogic means as substitutes. In that way it is often possible to continue the accustomed life, to reconnect it where fate tore it asunder and to thereby attain to the highest goal that can be striven for in the training of the prospective blind. And if we succeed in saving only part of the accustomed activity or to render possible an occupation related to it, a great deal, and as compared to the threatened absolute passivity a very great deal even has been accomplished. This refers particularly to intellectual spheres of work, since scientific attainments and experience are not lost through blindness because with reading and writing of blind script and stenography, with the transmission of same by typewriter, with the type calculating machine, drawing 'polster' and other auxiliary means, those accomplishments may be preserved and increased and be transposed into results of quite practical value. Very effective has been for this end the 'reconstruction method' elaborated by me, which enables the blind to reconstruct from single words, put down in blind script, sentences and later on compositions, scenes, orations, etc.*

"Of many cases corroborating this theory I will emphasize two as particularly convincing; one refers to a law student who began to be instructed by blind-pedagogic methods as soon as failing of vision had set in. He finished his curriculum, attained to the doctor's degree and is now able with quite a degree of success to work in a prominent law office, at the same time he is pre-

paring himself for the advocate's examination. Apart from being obliged to have legal papers read to him he is quite independent of outside help. The other case proves that education of one growing blind in advanced years is not alone possible but may be even very successful when undertaken at the right time, that means before sight has been lost entirely. This case refers to an author sixty years old, bowed down by fate's blows, who was able after some months of instruction to open a 'Schreibstube,' which for a year past he now has been conducting, with joyfulness regained, independently and with increasing patronage.

"But also in those cases in which talent and material circumstances compel the prospective blind to adopt a trade that has no relation to his former occupation it is much easier for him to learn such, dexterity and proficiency even after the beginning of total blindness are much greater and more surely founded if for the primaries some though reduced degree of vision has been available. That transference demanded for the training of the individual going blind can obtain to the character of permeation only then when the function of touch will be used in such a manner as if the object of comprehension should be produced plastically. Since in the beginning of this practice this function and its results are compared with those of vision it comes about that the most important and most effective experiences gained before blindness may be transposed into acts of the touching hand.

"This fact is also of greatest importance for the orientation in space for the prospective blind and it protests emphatically against the ill advised and insistent offering of assistance which circumscribes the independent movements of the blind, annihilating them finally and thus rendering him doubly miserable. I have known a young blind man who had formerly been an excellent gymnast but who then, thanks to the tender care of his friends, scarcely dared to rise from his seat, and who in walking through his room was pushed rather than guided. Suitable gymnastic exercises begun in the preliminary stages of blindness and practiced daily secure to the beginning blind as well as to the completely blind, not alone independence of movements but they also have a beneficial effect on the whole field of spontaneous resolution.

"Many blind show residual vision; this means a valuable possession as against the absolute loss of visual power; to preserve and increase it is an irrefutable postulate. The most important premise to that end the blind can create himself. It consists in taking care that he preserve the consciousness of the possession of a rest of vision. This is accomplished to the best purpose by never interrupting the practice of vision as long as possible and permissible at all, even when there is very little of it and by using it in connection with touching and touch-hearing.

"This whole exposé is in reality nothing but a single great request that I, a teacher of the blind, ask of you as masters of ophthalmology; I repeat it in conclusion: Give those unfortunate who are going to lose their vision wholly or nearly so in the preliminary stages of blindness over to instruction whereby can be preserved to them their intellectual life, and whereby can be returned their power to work and earn, and hence their independence, their human dignity and a great measure of the joy of living. I know I am asking much, but I am asking in the name of humanity. To keep up the illusion as long as possible only seems to be benevolence; it is purchased too dearly with a life of suffering. Sanity and salvation are only brought by truth."

Oakland (NOT Santa Cruz) is the place of the Annual Meeting of the State Society, April 15, 16 and 17, 1913.

* A private letter conveys information of a publication in course of preparation; in anticipation of such the author is good enough to elaborate on the most essential parts of his method as follows: "At first I make the blind write down in blind script short sentences from daily life; from each of these sentences the blind selects one word that seems to him the most important. Next, only these single words are put before him and he designates each of them with its initial letter; in case two or several words should have the same initial letter he is permitted to add yet another letter. From these letters the blind reconstructs the word, from the word the sentence, and this latter as accurately as possible. Herein they very soon attain to an unusual fluency as well in the annotation as in reconstruction. This method is practiced thus that the blind has to hear an address and during the hearing make notes of letters; at first such an address contains but few sentences but is extended gradually. At first the reconstruction is done immediately after the conclusion of the address; later the annotations are kept for hours or are not produced and used until the next day. Always, however, original and reproduction are subjected to comparison and in this way correctness is brought about more and more. It is remarkable how much memory grows stronger thereby."

GASSERECTOMY.

REPORT OF THREE CASES.

By J. HENRY BARBAT, M. D., San Francisco.

These cases are reported on account of the unpleasant complications encountered during operation. We are struck by the fact that this operation, when performed on the cadaver is very easy of accomplishment, but on the living body we are confronted with the one thing which makes intracranial surgery extremely difficult and at times fatal, and that is hemorrhage. While we now have, thanks to Harvey Cushing, Victor Horsley and others, numerous means to combat hemorrhage in this class of work, it will still remain the *bête noir* to the surgeon, and tax his resources in many cases. From the time we make the first incision until the last suture is placed we have to be on the alert to prevent the loss of too great a quantity of blood, and the conservative surgeon will often divide his operation into several stages rather than go on after a sudden severe loss of blood. The danger from sepsis following repeated operation can only be avoided by the most perfect asepsis from the beginning until the end of the operations, by the accurate closure of the scalp wound, and the administration of hexamethylene tetramine before and after the operations. Injury to the brain substance must be avoided by extreme care and gentleness in every manipulation inside the skull, and every advance made with the greatest deliberation.

Brilliance in brain surgery does not consist in being able to remove a tumor or a Gasserian ganglion in a few minutes, regardless of the patient's future, but in getting results, and *en passant* I might well say that this is the only principle which should guide us in any and all operative procedures. In spite of all the care which we may exercise we are often confronted with anomalies and unexpected conditions which may compel us to stop short and leave the operation incomplete.

Case 1. G. J., aged 55 years, farmer; had suffered from neuralgia of the trigeminus, right side, for about nine years. He was treated with medicines for three years without any great relief. I injected a 1½% solution of osmic acid into the supraorbital, infraorbital, mental and large palatine nerves according to Murphy's technic, in February, 1906, with perfect result for one year, when the infraorbital branch became painful, and I reinjected it with osmic acid. He was free from pain for two years, when he noticed that the sensation was beginning to get normal again and in a short time the pain returned in the second and third divisions of the nerve. I then used alcohol as the injecting material, but the relief was short and the pain returned with extreme violence following a sudden exertion. This did not yield to large doses of morphine, and the patient readily accepted my offer to remove his Gasserian ganglion. His general health was fair, but he had a marked arteriosclerosis. He was given 10 grains of hexamethylene tetramine every four hours for 24 hours preceding the operation. Head prepared in the usual manner, and half an hour before the operation he was given hypodermically morphine sulphate grains ¼, scopolamine hydrobromate grains 1/100, atropine sulphate grains 1/150. A horseshoe flap was made with the base just above the root of the zygoma, the bleeding was very free and required a large number of ligatures. Two small trephine openings were made at the lower angles of the

scalp incision, and the skull opened with a DeVillbiss bone forceps. The osteoplastic flap fractured at the base and turned down. I always make two bites with the bone forceps in the direction in which I wish the base of the bone flap to break. This weakens the bone considerably, and insures a correct break. When the bone flap was turned down the bleeding was profuse, the worst being at the upper margin of the wound which required packing between the skull and dura.

The dura was detached down to the foramen spinosum and the middle meningeal artery tied. Continuing the detachment of the dura a violent hemorrhage occurred which appeared to come from the cavernous sinus. After repeated tamponade the bleeding continued and it was deemed better to postpone the operation, so a small tampon was placed which controlled the hemorrhage and the skull closed. A tampon was also left at the upper margin of the wound as the bleeding was still profuse. The scalp was accurately sutured and dry dressings applied. The patient reacted perfectly and two days later the wound was reopened. As the last bit of gauze was removed from the base of the skull the hemorrhage recurred but could be controlled by placing a very small strip of gauze against the bleeding point which did not occlude the operating field. The second and third branches were easily exposed and sectioned at the points of emergence from the skull. Some bleeding occurred from the foramen ovale which was controlled with a piece of catgut packing. By grasping the cut ends of the nerves in a forceps and making traction the Gasserian ganglion was brought into view and the portion removed which gave origin to the two lower nerves.

It being impossible to check the hemorrhage from the cavernous sinus without leaving a tampon, I packed with a strip of gauze which was carried to the lower angle of the wound. The osteoplastic flap was replaced and the scalp accurately sutured, leaving only a very small aperture for the gauze strip. I began removing the strip on the second day and pulled out the last portion on the fifth day without any recurrence of the bleeding. The external wound healed perfectly and the patient went home to Morgan Hill 8 days after the second operation. Besides a paralysis of the second and third branches of the fifth he also had a paralysis of the third, fourth and sixth nerves on the right side which did not clear up for six months. Patient perfectly well up to present time.

Case 2. Mrs. H., aged 76 years, had been suffering with tic douloureux of the left side of the face involving both the superior and inferior maxillary branches of the fifth nerve for several years. The spasmodic pains would be started by the slightest irritation of any of the branches of the fifth nerve, recur every three minutes and last for hours. I injected the four branches with osmic acid as in the last case with complete relief for exactly two years when a second injection was given which lasted one year. The third injection was given in February, 1908, and lasted about two and one-half years, when the pain recurred, but the patient was able to hold out until February, 1912, when she came to me for operation.

She had lost considerable flesh on account of not being able to eat, as every mouthful caused excruciating pain. Heart and lungs in good condition, but arteries rather hard. The first operation was done on February 14, 1912. Furious hemorrhage followed the cutting of the scalp flap which was controlled with Hartman forceps on the concave edge and with ligatures on the convex edge. Both trephine openings cut branches of the middle meningeal artery and had to be tamponed. A third trephine hole also bled freely and had to be plugged for some minutes. It was then found that the blade of the DeVillbiss forceps was not deep enough to reach the inside of the skull which was at least ¼-inch thick at the trephine openings. I

was obliged to cut a channel $\frac{1}{4}$ -inch deep through the outer table of the skull corresponding to the horseshoe flap; this permitted the DeVilbiss forceps to be used and the skull was rapidly cut open. When the base of the flap was broken and turned back the whole of the exposed surface bled furiously, and by the time it was controlled with hot water, gauze pads and hemostats, the patient showed signs of shock and the osteoplastic flap was replaced and the scalp accurately sutured.

She rallied quickly and was kept under hexamethylene tetramine until the next operation five days later. When the bone flap was lifted it started considerable bleeding which was, however, easily arrested. The middle meningeal artery passed through a groove which was bridged over at short intervals with spiculae of bone, so that every attempt at separating the dura from the skull was followed by fresh hemorrhage, and laceration of the dura which allowed the escape of the cerebro-spinal fluid. The artery was finally caught and ligated at the foramen spinosum. The inferior maxillary nerve was uncovered and cut through just before its emergence through the foramen ovale. The last stroke of the knife brought a rush of blood which almost caused the patient to collapse. A rapid tamponade stopped the hemorrhage, but it would have been unwise to proceed with the operation. I believe that the inferior maxillary nerve in this case crossed the internal carotid artery without any interposition of bone and that I punctured the vessel with the point of the knife.

The tampon was left in situ and the flap again sutured in place. The patient recovered consciousness in a short time but found difficulty in talking. This condition increased, and she found it impossible to make known her wants by talking, and showed marked symptoms of pressure on the speech center. The skull was reopened $2\frac{1}{2}$ days after the last operation, with practically no bleeding; the removal of the tampon uncovering perfectly the region of the ganglion which was resected with its two lower branches, and the head closed. Speech returned completely in 5 days and the patient left the hospital 10 days after the last operation perfectly well.

Case 3. T. A. C., aged 63 years, blacksmith, had neuralgia involving all branches of the fifth on the right side. I injected osmic acid September, 1905, with perfect result except that the auriculo-temporal branch began to get very painful one year later, and was exposed and injected under local anesthesia. No further trouble was experienced for one more year, when the inferior maxillary began again and was injected in October, 1907. This lasted for four years, when a tic began which became rapidly unbearable, and was not relieved by injection of alcohol into the inferior dental and infraorbital, so operation was advised. Patient had marked arcus senilis, but was otherwise in fair condition. Very little bleeding was encountered at any stage of the operation. The dura was loosened along the anterior surface of the petrous portion of the temporal bone until the ganglion was reached and exposed. It was lifted out of its bed and detached from the dura, and the outer part resected along with the second and third branches. The bleeding from the foramen ovale was controlled by forcing a piece of folded up catgut into the opening. The middle meningeal artery was not ligated. Flap sutured and patient went home in ten days well.

With regard to hemostasis, the article by Harvey Cushing in the *Annals of Surgery* July, 1911, gives the best résumé which has appeared on the subject, and two of the methods given are relatively new. The use of small particles of either muscle or blood clot placed directly on a bleeding point and held there for a few minutes gives us a most use-

ful and efficient method of controlling hemorrhage from otherwise inaccessible places. The use of Cushing's silver wire staples is also a marked addition to the armamentarium of the surgeon, especially in checking bleeding from vessels of the pia or brain proper. When a vessel such as the middle meningeal or the small petrosal is cut or torn too close to its bony foramen to be able to grasp it with forceps the bleeding may be stopped by plugging the foramen with a small piece of fine catgut which has been tightly folded up. The nerves had better be cut with scissors instead of the knife, and the possibility of puncturing the carotid artery avoided. We must be always on the alert for anomalies, which, however slight, may cause most serious complications. It is astonishing how rapidly patients recover after these operations, provided the work has been carefully and accurately done and the brain substance not injured. I have seen no harm from opening of the dura, and the escape of the cerebro-spinal fluid; on the contrary, it facilitated the operation, by giving much more room to work in without making as much pressure on the brain.

Oakland (NOT Santa Cruz) is the place of the Annual Meeting of the State Society, April 15, 16 and 17, 1913.

PACIFIC ASSOCIATION OF RAILWAY SURGEONS.

Minutes.

The Tenth annual meeting of the Pacific Association of Railway Surgeons was held in San Francisco, August 30th and 31st, 1912; meeting called to order by the President, D. O. Hamlin, at 2:30 p. m.

Address by the President.

The following applications for membership were read: Drs. W. T. Cummins, San Francisco; Z. T. Malaby, Pasadena; R. R. Hammond, Stockton; Chas. R. Harry, Stockton; Barton J. Powell, Stockton; J. G. Mackay, Truckee; C. W. Page, Berkeley.

Motion made by Dr. Magee, seconded by Dr. Powell that Secretary cast ballot. Carried.

Secretary cast the ballot and applicants were duly elected as members.

President: There being no further new business we will proceed to the scientific program, as prepared by the Committee of Arrangements.

1. "Tuberculosis Among Railroad Employees"—Jno. C. King, Banning.
2. "A Pathological and Sanitary Study of a Typhoid Outbreak." W. T. Cummins, San Francisco.
3. "A Few Remarks on Typhoid." Geo. R. Carson, San Francisco.
4. "Supra-pubic Prostatectomy." Guy Cochran, Los Angeles.

5. "Fractures of the Patella—Treatment of." Rexwald Brown, Santa Barbara.
6. "The Treatment of Surgical Shock." R. L. Ramey, El Paso.

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7. "Report of a Case of Multiple Sarcomata." J. H. O'Connor, San Francisco.
8. "Hook Worm Disease and Its Importation Into California." J. W. Colbert, Albuquerque, N. M.
9. "Observations on Symptoms and Treatment of Suppurative Appendicitis." R. T. Legge, McCloud.
10. "Some Conclusions Regarding the Present Knowledge of the Vermiform Appendix." C. J. Teass, San Francisco.
11. "The Eye and Its Minor Injuries." A. C. Seely, Roseburg.
12. "Fractures" (Illustrated Lantern Slides). W. B. Coffey, San Francisco.

President: The scientific program now being completed we will proceed to unfinished business.

Next in order is the election of officers.

President.—Dr. David Powell, Marysville, was nominated by Dr. Coffey, seconded by Dr. Legge.

Dr. Morton moved that nominations be closed and Secretary cast the ballot. So ordered.

1st Vice-President.—Dr. S. Igllick, Orland, was nominated by Dr. Legge, seconded by Dr. Keys.

Dr. Kuykendall moved that nominations be closed and Secretary cast the ballot. So ordered.

2nd Vice-President.—Dr. S. J. Gardner, San Francisco, was nominated by Dr. Ketcherside, seconded by Dr. Carson.

Dr. Cochran moved that nominations be closed and Secretary cast the ballot. So ordered.

Treasurer.—Dr. E. M. Keys, present incumbent, was nominated by Dr. McCleave, seconded by Dr. Carson.

Dr. Gardner moved that nominations be closed and Secretary cast the ballot. So ordered.

Secretary.—Dr. G. R. Carson, present incumbent, was nominated by Dr. Coffey, seconded by Dr. Legge.

Dr. McCleave moved that nominations be closed and Secretary cast the ballot. So ordered.

President: There are two members to be elected on the Executive Board; nominations are in order.

Dr. R. T. Legge of McCloud and Dr. R. L. Ramey of El Paso were nominated by Dr. Coffey, seconded by Dr. Pinniger.

Unanimously elected.

Executive Board complete.—Drs. S. D. Pinniger, R. T. Legge, R. L. Ramey.

President: Any further business?

Motion was made by Dr. Edwards that this Association prepare a resolution to be sent to Members of Congress endorsing the "Owens Bill."

Dr. Crocker advised that the Texas Medical Association had adopted a similar resolution.

Motion seconded by Dr. Miller. Carried.

A vote of thanks was tendered the retiring President, Dr. Hamlin.

Motion made and seconded that meeting adjourn, to meet in San Francisco in 1913. Carried. Adjourned.

PRESIDENT'S ADDRESS.

By O. D. HAMLIN, M. D., Oakland.

Friends and Fellow Members:

Our Association is practically new on this coast, but we have done good work, and some very interesting scientific papers have been read before this Association at different times. There are two reasons for our meeting: the scientific program and the social opportunity. These meetings give members who are doing this class of work throughout the Pacific Coast an opportunity of becoming acquainted, and in our work the social opportunity is an important one—it is quite an advantage.

I had an opportunity of attending the meetings of some of the Railway Surgeons in the East this year, in Baltimore, and some of the papers were superior to many papers read at the A. M. A., so that these associations in the East are doing a great deal of scientific work. The railway surgeons are practically new all over and there is no reason why we should not do better than we have done, although there is no comment on the work that has been done in this association. We should get as many men in our districts as possible to join the association and attend the meetings to add to the interest of the scientific program.

THE TREATMENT OF SURGICAL SHOCK.*

By R. L. RAMEY, M. D., El Paso, Texas.

My subject, "The treatment of surgical shock," is one that I am very much interested in. There is perhaps no one condition that we have to encounter that is so misleading and deceptive. Oftentimes you have seen patients recover whose conditions were seemingly hopeless, and on the other hand you have seen life gradually slip away when there was apparently no reason for it. Before we go into the treatment of this condition we must go briefly into the physiology which is defined by most authors as a profound depression of the vasomotor nervous system, not necessarily following an injury but arising from any condition that may produce an impression upon the vasomotor center sufficient to cause paralysis or exhaustion of these nerves. In consequence we have a lowering of the blood pressure, an impairment of the heart's action and a disturbed respiration. Dr. Crile, who has, perhaps, done more research work along this line than any other man, has recently advanced a new idea of the physiopathological changes in the brain cells during a period of shock; that is, any stimulant, either psychic or traumatic, transmitted to

* Read before the Tenth Annual Meeting of the Pacific Association of Railway Surgeons.

the brain cells for a sufficient length of time or sufficiently strong may produce a disintegration of these cells, which may cause profound shock, collapse, or even terminate in death.

During the first half of the 19th century the mechanical conditions governing the circulation of the blood were carefully studied and at that time it was thought that the simple elasticity of the blood vessels was sufficient to control the circulation, but has since been proven by Claude Bernard and others that there is a more powerful influence that enters into the control of the circulation, viz.: the vasomotor nerves. The arteries are richly supplied with these nerves; also the veins to a very limited extent. The veins also being more deficient in muscular fiber than the arteries, have less power of contractility. The arteries are held in a state of constriction and in this manner keep the heart and coronary arteries filled with blood, so it is easily to be seen when these nerves are paralyzed the arteries become dilated and empty themselves into the veins, thereby diminishing the amount of blood both in the heart and the arterial circulation, hence lowering blood pressure including the pressure in the coronary arteries, producing a feeble and more rapid action of the pulse. It has been demonstrated that the great majority of this blood accumulates in the splanchnic area. Mall and others have shown that the portal system is supplied with vasomotor nerves somewhat similar to the arteries, while it is yet questionable whether the veins of the rest of the body are so supplied to any extent. Under normal conditions one can insert the finger into the foramen of Winslow thereby damming the blood from the general circulation produce all the symptoms of shock.

The treatment of this condition resolves itself into two classes, the preventive and curative. The preventive measures are such as getting your patient in the best possible condition before operation, clearing the bowels well but not purging, having him take freely of fluids several days before if possible. One of the most common causes of shock following abdominal section is the psychical effect of having to undergo a big operation. I have often seen patients go on the table with a nervous chill and continue in it throughout the operation. These patients as a rule take the anesthetic badly, and often make poor recoveries. I feel it my duty always to make the patient as comfortable as possible over the outcome of the operation without clearly deceiving him. The family and friends should, of course, know the true condition. If he is already in a state of shock from traumatism or otherwise it is always good surgery to wait unless you have a hemorrhage, for example, in the abdominal cavity or in the cranium, or elsewhere, which, of course, must be controlled immediately. The preparation of the field of operation should be the simplest that assures perfect technic. I believe it advisable to give a hypodermic of morphine and atropine in all cases before administering an anesthetic. Crile, Yandell Henderson, of Yale, Bloodgood and others are strong advocates of the use of nitrous oxide as an anesthetic, claiming that it is followed by practically no shock at all.

Blocking the field of operation from the central nervous system as described by Dr. Crile producing an anoci association is very effective when it can be done, but in some instances it cannot be done with any degree of satisfaction. It is in this class of cases we should consider the administration of spinal anesthesia, especially in injuries to the pelvic organs and of the lower extremities when for any reason general anesthesia would be dangerous and local anesthesia inapplicable.

The curative treatment: First and foremost in my opinion when drugs are indicated (and I want to emphasize we should be very careful not to over-stimulate a worn-out and exhausted heart) comes the intravenous administration of adrenalin, since we have a deficiency in the circulating blood we must direct our attention to the correction of this condition, and this, I believe, is most promptly met by the infusion of adrenalin. This can be administered with an ordinary infiltration syringe containing an ounce or so of saline and half a drachm of adrenalin injecting directly into the veins, it being a powerful stimulant to the vasomotor center as well as to the bloodvessels themselves. This can be done without incising the skin, allowing the arm to hang downward, applying a tourniquet just above the point of election. The needle can be readily inserted into the vein, thereby saving a great deal of time. In case of emergency the ordinary hypodermic will suffice, which should always be kept in reach during an operation. After the injection of adrenalin into a vein I have imagined I could detect a rise in blood pressure in less than ten seconds. Crile has of late advocated the use of adrenalin in saline infusion intra-arterially, injecting it towards the heart, claiming to get a more speedy effect from the drug. I do not believe it is necessary to use much saline unless you have had hemorrhage. In shock the amount of blood is not supposed to be diminished, but unequalized, the veins containing the greater amount of all the blood in the body, so you can see by throwing a big amount of saline into the veins already distended you may mechanically flood the right heart and do great harm. Of course, if there has been loss of blood an intravenous infusion of two or three pints of saline is strongly indicated. The patient should be kept as quiet as possible. All movements tend to increase the collapse. And if there is an injury it should not be interfered with until later unless there is hemorrhage, as above stated, which, of course, should be stopped. The patient should be kept warm with blankets, hot water bottles, etc. Hot coffee should be given by the rectum, or a hot saline injection if the coffee is not convenient. Ordinarily the foot of the bed should be elevated to increase the blood pressure in the heart and brain. However, if this produces a cyanosis the patient should be brought to a horizontal position. Bandaging the extremities, forcing the blood back into the body is recognized as a good mechanical treatment. Atropine is, in my opinion, second only in importance to adrenalin, given in one-fiftieth to one-one hundredth of a grain. Hare says of atropine, to use his own words: "The drug acts as a powerful stimulant

upon the vascular system; it dilates the capillaries of the skin but contracts the vessels of the splanchnic area. This is why it is so valuable in shock and collapse; it drives the stored-up blood in the veins of the splanchnic area into the general circulation, thereby raising blood pressure." Potter also says in this connection that atropine stimulates the vasomotor ganglia throughout the body. The use of atropine can almost be restricted to those cases in which you have marked pallor with relaxation of the muscles and profuse perspiration. The use or abuse of digitalis, strychnine and nitro-glycerine that has so long been used in these cases indiscriminately I believe to be without sound therapeutic foundation, to say the least. And indeed, in my opinion, may prove even dangerous. Take for instance, nitro-glycerine, the most prompt and powerful of the three; all authorities claim it acts by paralyzing the vasomotor and sympathetic nervous system, and the muscular coats of the arteries themselves. It may stimulate the heart and increase its force, but in so doing it may be harmful. We already have a paralyzed vasomotor center, consequently we have a deficient amount of blood in the arteries, therefore we do not want the heart stimulated until it has something to contract upon.

Digitalis acts particularly by contracting the heart muscle itself. Every form of a dilated heart arising from any pathological condition is a fit subject for digitalis; therefore I believe that digitalis is beneficial in those cases where you have shock from prolonged exhaustion of your vasomotor center, with a weakened and dilated heart muscle, but I doubt its efficiency in an acute collapse. Its action by stimulating the pneumogastric would be emptying the heart and arteries of what little blood they have left to contract upon. Digitalis is a good drug, but not until you have established your vaso constrictors.

We will now speak briefly of strychnine. Its action is somewhat similar to digitalis. I do not believe strychnine is of much value in acute shock. Indeed, it may do harm. There is one other drug that is commonly administered to patients found in shock—morphine. Under no circumstances, in my opinion, should it be given to a patient if he has reached the state of profound collapse, but if there is consciousness of pain, or restlessness, it should be administered. The household remedy, whisky, which is always on hand, should not be given at all. It may obscure both the cause and extent of the injury. The Crile pneumatic suit which acts by forcing the peripheral circulation to the center, thereby increasing the pressure, does not tend to relieve the true cause of the condition. It acts simply in a mechanical way. Sometimes by the simple dilation of the sphincter and you may relieve a patient in acute collapse. The transfusion of blood which was so commonly used in olden times has been a recognized procedure since the early part of the 19th century, but had practically become obsolete until recently, when it was again revived. I believe it should be resorted to only when there has been a hemorrhage; even then I think most cases best relieved by saline infusion.

Gentlemen, in conclusion I wish to state that

it is my opinion that many sudden deaths following accidents and tedious operations that are attributed to other causes such as emboli, thrombi, etc., are due to shock, and I repeat by the constant vigilance of the anesthetist and the surgeon, that this condition in many cases can be avoided. The drawing upon a pedicle, the rough handling of the intestines, all tend to produce shock and should be avoided. There are critical moments when by prompt action our patients' lives may be saved.

Discussion.

Dr. C. J. Teass: I agree most heartily with what has been said regarding the mind and the limited use of drugs, and will not consume time by repeating anything that has been said, but I have not heard the subject of heat mentioned and I feel that it is too important to allow the subject to be closed without emphasizing a few points about keeping the patient warm. I have seen many a badly injured patient brought into the operating room, placed on a cold table, and kept exposed for many minutes while a constant process of scrubbing the entire body was taking place, the evaporation from the surface adding constantly to the patient's shock. Rather by far, not scrub such a patient at all, for the simpler you make your technic, and the quicker the patient is made as comfortable in bed as possible, the greater will be his chances toward ultimate recovery. I remember only too well when I was doing pioneer surgical work in several different mining camps, that I soon found out that prolonged scrubbing and ether anesthesia cost the lives of several patients with badly mangled limbs, so I soon simplified my technic by injecting morphine with cocaine into the exposed nerves, washing with tincture of iodine, and cutting out excess of dirt with the scissors and using silk-worm gut that had been kept in tincture of iodine after simply soaking it in hot lysol solution for a few moments. After the adoption of such a simple and quick method of handling emergency cases, they ceased to give me such great concern, for I knew they would get well.

Dr. Rexwald Brown: The point of the mental attitude of the patient toward the doctor is to me one of the most interesting elements entering into shock. The patient who has come to the doctor's office knowing that surgical procedures are necessary, realizing that they are necessary, going home and talking the matter over with his friends and family, with his mind against operative procedure all the time, is liable to shock. The woman who goes into the operating room with the idea that she is likely to die, in a large number of instances will die, merely from shock. Crile has called attention to this. This was brought home to me recently. Two years ago a patient came to me in need of operation (hysterectomy). She fought against it for two years, but finally submitted. She went into it saying that she would die, although it was a simple hysterectomy. She died three days after the operation from nothing in the world but shock.

Dr. Powell: In the treatment of surgical shock we must be guided entirely by the cause of the shock. In hemorrhagic shock the treatment must be different from that of nervous or psychological shock. It is well enough for Dr. Morton to tell us that he can take a patient into the operating room and under the pretense of making an examination, perform a hysterectomy without her knowing that he has operated on her. But when patients come to us seriously injured, and suffering from shock we cannot treat them that way. So far as the use of drugs is concerned, when the patient is nervous and dreads surgical procedure, I think a hypodermic of morphine will put him in better condition, and there will be less danger of subse-

quent shock. If the shock is caused by nervous depression, stimulants, warm applications to the body surface, and morphine is the best treatment. Adrenalin has been spoken of favorably and is undoubtedly one of the best arterial stimulants, but its effects pass off too quickly.

Dr. Hildreth: The paper just read seems to devote more time to injury than to acute shock. I would call attention to the fact that this is a railroad society, and we are supposed to have principally emergency cases where rapid action is necessary. Perhaps I will make some innovation here. I have treated a good many cases of injury and shock following in an otherwise healthy individual in full possession of his mental and physical faculties. The influence of shock seems to me to be a depressing one upon the pneumogastric ganglion and the organs in control of that ganglion which draws three pairs of nerves of the stomach and heart and also influences the portal circulation. I conclude that in shock it would be necessary to establish peristalsis, especially of stomach. In the administration of a drug, there is one in which I now place my reliance. I had a case with both legs mashed to pieces; the shock increased, and the patient was sinking rapidly. I administered by mistake a good dose of apomorphine. In less than ten minutes the patient said to me, "Doctor, I will make it." Then I began to figure out what I had done. The next case was in my private practice, a lady severely injured and determined to die—and I thought she would. I gave her apomorphine and diverted her mind from the purpose of dying. Our surgeons will bear me out that the crushed cases are the worst ones in our practice, although they do not bleed to any extent. It would be almost impossible to take charge of a badly injured case in a country practice without letting some one give that patient whisky. I had a case last summer of rattlesnake bite, on middle finger of left hand; the victim shook off the snake and did the natural thing of course; he sucked on it right away and before I got there he had taken 1½ pints of whisky. I loaded him with apomorphine and got the whisky out of him. I told him he didn't need any more whisky, but to keep right on sucking. I would suggest that when you find all other means fail, you give them a dose of apomorphine. You may find it will help you as it did me. I find in these cases of shock by reptile poisons much mental influence; this as well as the "nervous paralysis" seems relieved by apomorphine, and in no case in which I have used it for "shock" has emesis followed.

Dr. O. D. Hamlin: Undoubtedly to all surgeons and men doing emergency work, the question of shock and hemorrhage is one to which we cannot give too much attention. Dr. Powell struck my idea with the classification of shock—all cases are not due to the same cause. In treatment I think alcohol and morphine are often valuable. Dr. Ramey is against alcohol, and I think that in cases of surgical shock that is true; but in psychical (?) shock there is nothing better than alcohol. In the surgical shock due to crushing of limbs or intestines, the emptying of the arterial system into the venous, you have a different pathology, and adrenalin is, I think, one of the most important drugs. It has been proven by experiments that the blood pressure will keep up under adrenalin 12-18 minutes; it then lowers very rapidly. If you are working for a very short period, there is no drug in the world which takes the place of adrenalin. Where you have gross pathology, as a crushed limb, where impulses are continually being carried through the nervous system, morphine is ideal. In intestinal work, where shock comes from manipulation of the intestines, adrenalin would be valuable. But in thinking of shock, we should classify it. When you have shock and hemorrhage combined, you must replace the lost blood by blood or salt

solution. I think the classification is of great importance, and no one treatment will cover the whole subject.

Dr. Ramey, closing discussion: At the Texas State Medical Association meeting, I heard a great deal of emphasis laid on the idea of fear by Dr. Crile. The speaker said that if fear could be eliminated absolutely you would have hardly any shock, and he went so far as to say that if you could block your field of operation, shutting it off from the central nervous system, there would be no shock at all; you could operate as long as you wanted without shock to the patient. He claimed that neither ether nor chloroform produces this condition. He said that if you operate under ether, every impression is carried to the central nervous system, which is not the case with nitrous oxide anesthesia. As to the use of drugs in shock, I referred to nearly all that have been used simply to say that I do not believe much in them. I rely principally upon two drugs when indicated in the treatment of shock—atropin and adrenalin; the latter should always be given intravenously with a little saline solution. I doubt that fear plays as important a part in the production of shock as advanced by Crile. We all know that extensive burns and traumatic injuries following railway accidents produce the most profound shock. The treatment of shock following laparotomies consists principally in its prevention as I stated in my paper.

TUBERCULOSIS AMONG RAILROAD EMPLOYEES.*

By JNO. C. KING, M. D., Banning.

Tuberculosis is ubiquitous, therefore railroad employees suffer from it. The percentage of morbidity is probably less among them than among any other large mass of employees, except those in the army and navy. They are obliged to submit to physical examination prior to employment. Life insurance actuaries claim that examination discriminates in favor of the company for a period not to exceed five years. Likewise, the examination of our men protects the company for only a limited, though uncertain, time. In the practice of my specialty I see many cases of tuberculosis among railroad men, from both eastern and western roads. As a rule, the hygienic environment of our men is above the average, particularly on this coast; partly owing to the climate, in part to the nature of the work, and largely to the fact that our company officials are quick to remedy hygienic defects. It has several times happened that superintendents and roadmasters have remodeled station and section houses in my district, at my request, and have changed plumbing and drainage.

In attempting to group the men we find that engineers and firemen are quite exempt from the disease. On the other hand, Pullman conductors furnish a large quota. Mexican peons, laboring as section hands, are frequently tubercular. Trainmen are not subject to the disease as commonly as other men of similar social grade. The same is true, I think, of shopmen. When these people succumb it is due to unhygienic housing and living rather than to shop conditions. Office men are attacked more frequently than other employees. And yet, they suffer less than occupants of average busi-

*Read before the Pacific Association of Railway Surgeons, San Francisco, 1912.

ness offices, because railroad offices usually provide larger cubic area of fresh air than others. On the whole, there are few lines of employment open to workingmen where the conditions of labor involve so little menace from tuberculosis. The fact remains that a certain number of our men do have the disease. What shall we do with them?

The chief surgeons of several of our California roads have furnished me with data which I beg leave to present. Dr. E. A. Bryant, of the Pacific Electric, writes: "Impossible to give accurate percentage, but should say that not more than one-half of one per cent. are tubercular. The policy of the company is not to accept for employment persons infected with tuberculosis. We have a rule not to admit tubercular patients to the hospital, but give them home treatment. Of course, in case of need the rule is not enforced. The company does not provide sanatorium treatment.

Dr. Huntington, of the Western Pacific, states: "As the Western Pacific Railway Company is a recent organization, we have discovered a very small percentage of our employees suffering from tuberculosis, not to exceed one-fourth of one per cent. Employees who have acquired tuberculosis while in the service of the company receive marked consideration. The company has, thus far, maintained no hospital, but has contracts with several hospitals. Tubercular subjects are permitted to remain in a hospital for a reasonable length of time. No definite limits have ever been established. The matter of the establishment of a tubercular sanatorium has never been considered."

Dr. Cochran, of the Salt Lake, reports: "We have from our own office not more than half a dozen cases per year. The policy of the company is to eliminate such cases from the service. We have no arrangement for admission to the County Hospital, for we dispose of each case as we are best able to under the circumstances individually, usually caring for them at their homes or sending them to a sanatorium, for the company does not provide for any treatment of such cases. Each case is dealt with as seems most advisable for that individual."

Dr. Morrison, of the Santa Fe, states: "We keep no special record of employees suffering from tuberculosis. The number is small, owing to the physical examination before entering the service. Under our rules, chronic diseases acquired prior to entering the service are not subject to treatment by our Hospital Association. Each case found suffering with T. B. is handled on its merits. If a man has been in the service a number of years we care for him as long as possible under conditions which seem to be required by his particular case. At our Association Hospital at Albuquerque we have a number of very fine 'tent houses' where we have sent a number of T. B. cases during the past four years, and have had very satisfactory results."

Dr. Ainsworth, of the Southern Pacific, records: "Of 2780 cases treated in the hospital for the fiscal year ending June 30, 1911, twenty-seven were tubercular; of 76,139 treated outside of hospital during the same period, 151 were tubercular (ap-

proximately one-fourth of one per cent.). Employees with tuberculosis are kept on the company's payroll as long as they are able to report for active duty. Tubercular employees, the same as all other employees, are entitled to one year's hospital privileges. The company has provided special facilities for the care of tubercular patients at the General Hospital in San Francisco."

It will thus be seen that while tuberculosis is uncommon, each company must face the problem. I wish to comment on two or three phases of the subject and to suggest that better opportunities for recovery be offered to those included in the title of this address than can be afforded in a general hospital.

All modern advance in our knowledge of tuberculosis may be summed up in early diagnosis and rational treatment. Our conception of its pathology has not changed during the past five years, except as regards the (yet doubtful) constant presence of the tubercle bacilli in the blood stream. It would seem that early diagnosis is the key to the situation. In my special work about one hundred physicians are in the habit of sending to me occasional cases of tuberculosis. As the years pass I note an increasing number of patients who come in the incipient stage, with a corresponding increase in the percentage of recoveries. Some of these gentlemen almost invariably send very early cases, with others the reverse is true. I have noted, also, that men who send incipient cases are either nose, throat and chest specialists or general practitioners, while men who specialize in surgery, gynecology and neurology more frequently send advanced cases. I am, therefore, inclined to believe that the common run of general practitioners recognize the disease earlier than do their more noted colleagues who have achieved greater distinction. Aside from those who have come to me primarily as company surgeon, I have never had a railroad employee referred to me in the incipient stage. There are, doubtless, many explanations of this fact, but one reason is that our attention is concentrated upon apparently more serious conditions. These people seem to have so little the matter with them.

Early diagnosis is an art rather than a science. There are no pathognomonic symptoms. The physical signs are yet doubtful. Tubercle bacilli are never present in the sputum until the second stage; that is, until some breaking down of lung tissue has occurred, however minute it may have been. Even then many samples of expectoration may not contain them. While presence of the bacillus is positive evidence, its absence is without diagnostic import. The tuberculin reactions, as the Moro test, are valuable, but the reaction may be caused by latent tuberculosis, by some old, encapsulated tubercle, when the disease does not even threaten activity. Repeated examinations have convinced me that the blood picture is usually normal, even the hemoglobin content. Blood pressure still remains unaffected and Arneth's index, if ever useful, is a later phenomenon. Examination of the urine, unless lesions exist primarily in the kidney or bladder, does not illumine the problem. The

Diazo reaction occurs late, if at all, and indicanuria and phosphaturia are not significant. The importance of the daily temperature curve cannot be exaggerated, but occasional office observations are worthless. An accurate thermometer should be used, at least every two hours from early morning till late evening. The curve will slowly rise from 97° or 98° to 99° or 99½°, to fall again as night comes on. This curve will be quite steady and very persistent. If it continues, without intermission, for ten days or two weeks, the case is more than suspicious. The patient will complain of a little physical weakness and loss of ambition. He will not complain of poor appetite, but inquiry will elicit the symptom, together with somewhat vague evidence of indigestion or mal-assimilation and consequent decline in weight.

There is often a little pleurodynia, fugitive myalgic pains in the intercostal muscles. A frank attack of pleurisy is almost always tubercular. The nasal and buccal mucous membranes are apt to be flabby and pale, more noticeable because the percentage of hemoglobin remains about normal. Pottenger's sign can sometimes be detected. A small, fine, moist rale may be heard—only after a cough. Occasionally a little bloody expectoration brings the patient to one's office. Unless its origin in the nose or throat, or from organic heart disease, actinomycosis or malignancy can be definitely determined we must assume it to be tubercular. The patient's family history must be searched to determine his tendency to disease. His personal history, environment and associations must be carefully investigated.

These few points are mentioned merely to indicate the difficulty of early diagnosis. It is comparable to the early diagnosis of gastric cancer and failure bodes the same disaster to the patient. The clinical artist will interpret the picture. The average man will prescribe some worthless tonic and, months later, will send his patient to the sanatorium—when it is too late. We cannot expect the average busy railroad surgeon to devote the necessary time to these cases but every railroad has on its staff competent men to whom the patient can be referred for verification of suspicious symptoms. The time will arrive, of course, when any one can make the diagnosis; by that time it is often a mere preliminary to the autopsy.

The successful treatment of these early cases is a distinct specialty. The work and the conditions of work in a general hospital are so foreign to the needs of these patients that the very best things can rarely, if ever, be done for them there. The necessity for daily expert supervision cannot be too forcibly insisted upon. Many surgical risks recover notwithstanding faulty asepsis. So, too, many consumptives get well without modern sanatorium treatment. In each instance, however, the percentage of good results is far below modern possibilities. The value of specialization is conceded in principle. The oculist, the surgeon, the alienist each covers a recognized field. But every man in the profession deems himself quite competent to treat pulmonary tuberculosis. Now the average man's success in this business is comparable to the ab-

dominal surgery of the general practitioner. In either case some brilliant results may be secured, but in both instances there will be inability to successfully cope with unexpected complications. It is improbable that an audience of surgeons would be interested in the details of sanatorium treatment. And yet, its value consists of attention to detail and of adapting the details to the individual. The diet, regulation of daily rest and exercise, hydrotherapeutic measures and dozens of other items vary with each patient. Even good surgical nurses do not apprehend the needs of this class and to achieve results the physician must be in daily contact with the patient.

Another point! For many years some particular climate was considered essential to the treatment of pulmonary tuberculosis. At present, the general opinion seems to be that one climate is as good as another; that climate is without therapeutic value. Now climate (which includes altitude, relative humidity, temperature, air currents, soil, drainage and many other elements) does exert physiological effects upon the human body in both health and disease. For instance, where I am located the climate acts disastrously upon all cases of organic heart trouble. Under the same treatment pulmonary tuberculosis will often prosper in one climate and succumb in another.

Because of these many reasons that I have hinted it would seem wise for our railroad companies to establish sanatoria for the treatment of employees suffering from early tuberculosis. This plan need not involve large expenditure. Sanatorium efficiency does not depend upon an elaborate plant. The building and equipment simply constitute an instrument to be used with more or less skill according to the ability of the medical man in charge. Enough individual bungalows, at a cost of \$100 apiece, or less, together with a modest administration building are all that is required. Each company has men on its medical roll who reside in suitable climates and who are specially trained for this work. To one of them could be delegated the care of all early cases. If a more ambitious program is desired several of the roads could combine to carry it out.

The most precarious time in the life of a consumptive is the year following his discharge from the sanatorium as an arrested or as a cured case. His finances have become straitened; his business demands extra nervous expenditure; he feels the freedom of a man whose death sentence has been reversed; he does not realize the true situation. Many of my worst cases have been discharged from some institution as cured. In a former talk, before the State Society, I advocated the rule that no patient should be included in the list of arrested or cured cases until after three years have elapsed from the date of discharge. If sanatoria would adopt this rule their statistics would be less attractive but more accurate. When one of you removes a cancerous breast you do not report the patient cured when she leaves the hospital. You await developments. It should be so with consumptives. For at least one year after leaving the sanatorium the patient should remain under close observation.

He should be carefully examined every two or three months and his mode of living strictly regulated. It should be much easier to follow up railroad employees in this manner than to keep track of private patients.

In conclusion I wish to refer to a point that should appeal to a surgical audience. It is not unusual to refuse or to postpone some needed surgical procedure because the patient is suffering from incipient tuberculosis. And yet, when surgery is indicated, tubercular patients bear the operation well, suffer little from shock and, for some reason, the tuberculosis frequently improves. Instead of being a counter-indication to surgical work incipient tuberculosis is a very cogent reason for doing it. Time and again I have removed nasal obstructions, tonsils and adenoids with decided benefit to the pulmonary condition. Nor are the benefits of operative work restricted to that done on the respiratory passages. In my sanatorium to-day is a young woman whose lungs were softening; she was rapidly declining. For a long time she had grumbling appendicitis. My consultants opposed operation because of her pulmonary tuberculosis. However, I opened her and removed the diseased appendix. She has gained about twenty pounds in three months and her lungs are clearing up. A year ago I opened a blacksmith who was in bad shape. The appendix contained many tuberculous nodules and the peritoneum was studded with tubercle. The man is now well. These cases are merely illustrative. And yet, I have seen so many pulmonary cases recover after work on pus-tubes, or gall-bladder or appendix that I have become quite optimistic. I do not pretend to specialize in surgery but experience has taught me that moderate tubercular involvement of the lungs is no bar to otherwise indicated surgical work. These statements may be simply "carrying coals to Newcastle" but so often such work has been opposed by my consultants that it seemed worth while to refer to the subject. It may be assumed that the benefit to the lungs is derived from the improved nutrition and the lessened insult to the nervous system incident to the removal of the surgical disease.

Discussion.

Dr. Wm. Ellery Briggs, Sacramento: In regard to surgical operations in tuberculous troubles, I was rather interested to know in what kind of cases the author would advise the removal of tonsils and do large operations for nasal stenosis. It has been my practice to discourage removal of tonsils where there was extensive pulmonary disease and where it seemed as though the tonsils could not be the source of continued reinfection. I still believe that the depressing effect of considerable surgical operations (removal of the tonsils if not sources of reinfection) are distinctly contraindicated, and I advise against it when there is extensive pulmonary disease. I would like to know Dr. King's views on this subject. Of course there are many nasal conditions where surgical operation would improve the breathing, which would be a reason for the operation.

Dr. King: In regard to operative measures, no one wants to operate on a moribund case. If the patient is too far advanced operation is never advised. There are three reasons for not operating:

1, poor resisting power; 2, fear of shock; 3, fear of infection. I do not think the resistance is affected by the presence of tuberculosis and shock is not to be feared as much as in other cases. Surgeons will take the view that shock is more likely to occur in those who are robust than in those who are already weakened by disease. Chances of infection are not increased by the disease. To discuss tuberculin would take too much time. I use it in about one-third of my cases. There have been some very valuable results; but as a rule I think it disappointing, and there are great possibilities of harm being done by it. There is always the possibility of harm resulting, and a slight probability of great good in some cases.

SOCIETY REPORTS

ALAMEDA COUNTY.

The annual meeting of the Alameda County Medical Association was called to order by the president, W. A. Clark, at the Y. M. C. A. building, Tuesday evening, Dec. 17, 1912, at 8:30 o'clock.

The following program was given:

1. The Value of the Color-fields in the Diagnosis of Syphilis. Dr. H. G. Thomas.

2. Syphilis as an Important Factor in the Etiology of the Functional Neuroses. Dr. J. D. Ball.

These papers brought out interesting discussions.

Reports from the president, treasurer, secretary and Dr. David Hadden, chairman of the Medico-Legal Committee, were read. The reports showed the society to be in a satisfactory condition. The outgoing officers asked and the incoming ones promised for themselves and the society good and earnest work for the coming year.

The election of officers, councilors, delegates and alternates resulted as follows: President, Dr. M. L. Emerson; vice-president, Dr. Dudley Smith; secretary-treasurer, Dr. Elmer E. Brinckerhoff; councilors, Drs. N. H. Chamberlain, J. A. Ellis, W. H. Irwin, C. W. Page, Alvin Powell, G. G. Reinle; delegates, Drs. Elmer E. Brinckerhoff, T. J. Clark, W. A. Clark, David Hadden, and alternates, Drs. L. P. Adams, C. G. Bull, C. E. Curdts, A. Galbraith, A. F. Gillihan, J. L. Lohse, J. L. Milton and R. T. Sutherland.

ELMER E. BRINCKERHOFF, Secretary.

BUTTE COUNTY.

The Butte County Medical Society held its monthly meeting at the offices of Dr. Gatchell at 8 p. m. January 14th, the president, Dr. C. L. Browning in the chair. Members present: C. L. Browning, N. T. Enloe, D. H. Moulton, W. L. and E. F. Gatchell and J. L. Gougout.

Dr. Gougout read a paper on Bright's Disease.

The following officers were elected for 1913: President, P. L. Hamilton; vice-president, T. B. Reardon, of Oroville; secretary and treasurer, Ella F. Gatchell; board of censors, W. L. Gatchell; delegate to State Society, D. H. Moulton; alternate, C. L. Browning.

ELLA F. GACHELL, Secretary.

SAN JOAQUIN COUNTY.

The San Joaquin County Medical Society held its annual meeting in the offices of Dr. D. F. Ray December 27th, and elected officers, directors and committeemen for the ensuing year, as follows:

President, Dr. W. J. Young; first vice-president, Dr. W. E. Gibbons; second vice-president, Dr. A. W. Hoisholt; secretary, Dr. R. T. McGurk; dele-

gates to the State Medical Society, Dr. Barton J. Powell, Dr. A. W. Hoisholt and Dr. J. D. Dameron.

The committees were as follows: Ethics—Dr. H. E. Sanderson, Dr. Hudson Smythe, Dr. Mary Taylor, Dr. R. T. McGurk and Dr. Barton J. Powell; admission—Dr. Minerva Goodman, Dr. Margaret Smyth, Dr. Hudson Smythe, Dr. A. W. Hoisholt and Dr. E. A. Arthur; finance—Dr. J. D. Young, Dr. L. R. Johnson and Dr. F. P. Clark; program—Dr. Margaret Smyth, Dr. Minerva Goodman and Dr. C. F. English. The directors are: Dr. C. R. Harry, Dr. W. J. Young, Dr. S. E. Latta, Dr. W. E. Gibbons, Dr. A. W. Hoisholt, Dr. F. P. Clark, Dr. R. T. McGurk, Dr. Barton J. Powell and Dr. Hudson Smythe.

The society decided that on account of the short notice given the local organization to raise funds for a convention of the State Medical Society here, it could not accept the offer for sessions in Stockton.

ANNUAL MEETING OF THE LOS ANGELES COUNTY MEDICAL ASSOCIATION.

The annual meeting of the Los Angeles County Medical Association was held on Thursday evening, December 19th.

The officers and committees for the coming year are as follows:

Officers.

Wm. M. Lewis, M. D., Auditorium Bldg., President; A. S. Lobingier, M. D., Story Bldg., Vice-President; George H. Kress, M. D., 245 Bradbury Bldg., Secretary-Treasurer and Editor of the Bulletin.

Board of Councilors.

Wm. M. Lewis, M. D., Chairman (ex-officio); George H. Kress, M. D., Secretary (ex-officio); Stanley P. Black, M. D. (1915); Dudley Fulton, M. D. (1915); A. S. Lobingier, M. D. (ex-officio); H. Bert Ellis, M. D. (1913); Albert Soiland, M. D. (1913); W. W. Richardson, M. D. (1913); George L. Cole, M. D. (1914); F. C. E. Mattison, M. D. (1914); W. Jarvis Barlow, M. D. (1914); O. O. Witherbee, M. D. (1915); F. W. Thomas, M. D. (Pomona Branch); A. C. Sillery, M. D. (Long Beach Branch); W. H. Parker, M. D. (Santa Monica Branch); W. H. Dudley, M. D. (Eye and Ear Branch); W. D. Dilworth, M. D. (Pasadena Branch).

Branches.

Pasadena—W. D. Dilworth, M. D. Chairman; Eliot Alden, M. D., Secretary.

Pomona—L. M. Breed, M. D., Chairman; N. J. Rice, M. D., Secretary.

Long Beach—W. H. Newman, M. D., Chairman; Thomas L. Rogers, M. D., Secretary.

Santa Monica—John A. Balsley, M. D., Chairman; G. A. Fielding, M. D., Secretary.

Eye, Ear, Nose and Throat—H. A. Kiefer, M. D., Chairman; J. M. Brown, M. D., Secretary.

Committees.

Membership—Dr. John C. Ferbert, Chm. (1912); Dr. W. R. Molony (1914); Dr. L. M. Powers (1915).

Medico-Legal (Ethics)—Dr. W. T. McArthur, Chm. (1914); Dr. Wm. Duffield (1912); Dr. W. W. Richardson (1913).

Certified Milk—Dr. Fitch C. E. Mattison, Chm.; Dr. George H. Kress, Dr. L. M. Powers, Dr. Stanley P. Black, Dr. Titian J. Coffey, Dr. H. B. Stehman, Dr. Jas. H. McBride, Dr. Wm. L. Zuill, Dr. Samuel L. Salisbury, Dr. Elmer A. Clarke, Mrs. Charles F. Edson, Mrs. W. W. Orcutt, Mrs. Wil-

bur E. Sanders, Dr. George H. Hart, Dr. P. V. K. Johnson.

Public Health Committee—Dr. Stanley P. Black, Chairman; Dr. L. M. Powers, Dr. F. C. E. Mattison, Dr. C. C. Browning, Dr. P. C. H. Pahl.

Board of Permanent Quarters—Dr. H. Bert Ellis, Chm. (1914), President of the Association (ex-officio); Dr. F. C. E. Mattison (1913); Dr. Walter Lindley (1915); Secretary of the Association (ex-officio).

Malpractice Defense—Dr. C. B. Nichols, Chm.; Dr. J. H. Seymour, Dr. H. G. Marxmiller.

Committee on Contract Practice and Hospitals—Dr. F. C. E. Mattison, Chm.; Dr. Stanley P. Black, Dr. Andrew Stewart Lobingier, Dr. L. M. Powers.

Committee on Necrology—Dr. Frank D. Bullard, Chairman; Dr. John Dunsmoor, Dr. George Malsbary.

Committee on Hospitals and Contract Practice—Dr. O. O. Witherbee, Chairman; Dr. A. S. Lobingier, Dr. Dudley Fulton.

Scientific Program—The Secretary of the Society (ex-officio).

It was proposed to change the Constitution to make the dues fifteen dollars yearly, instead of twelve dollars. The article on Funds and dues would then read as follows:

CONSTITUTION AND BY-LAWS.

ARTICLE IX.

Funds and Dues.

"Section 1. Funds shall be raised by a per capita tax of Fifteen Dollars (\$15.00) per annum for members, the entire sum to be payable either in advance, or in two installments of Seven and a Half Dollars (\$7.50) each, the first installment to be due on January 1st, and the second installment to be due on July 1st of any year; provided, that new members (excluding under this term former members who have allowed their membership to lapse) who apply for admission into the Association in July or thereafter of any year, shall pay only the semi-annual assessment of Seven and a Half Dollars (\$7.50) for that year.

"Section 2. Funds may also be raised by voluntary contributions, from the publications of the Association's transactions, and in any other manner approved by the Board of Councilors.

"Section 3. Any member whose semi-annual payments of dues shall remain unpaid two months after the date such semi-annual payments are due; namely, unpaid after March 1st or August 1st, shall be held as suspended without further action of the Association, but any member so suspended shall be reinstated in full membership if the entire amount due is paid prior to October 1st of any year. If a semi-annual payment previously due, remains unpaid on June 1st or on November 1st, he shall cease to be a member of the Association, but a member thus dropped may be re-instated by paying in addition to all arrears the sum of One Dollar (\$1.00), provided such re-instatement is made before December 1st of the same year.

"Section 4. In one of the December Bulletins of each year, shall be printed a list of the members who have been dropped for non-payment of dues, under the heading, 'List of Those Who Have Been Dropped for Non-Payment of Dues for Current Year.'

"Section 5. Any member who has been dropped for non-payment of dues as per Section 4 of this article, in order to again become a member must pay all back dues plus penalties, and send in an application as if he had never been a member. This provision is also to apply to members who resign for other reasons than absence from the city.

"Section 6. Any member of any other county medical unit in California who wishes to transfer to the Los Angeles County Medical Association must state the amount of dues paid for the current year to the Society of which he is a member, and must then send a check for any difference due to the Los Angeles County Medical Association, before his application can be voted upon."

The following argument was made in defense of this proposed increase in dues:

In a straw vote taken during the discussion of the report of Mr. Morrow, on the prosecution of illegal physicians, it was shown that the Society members present felt that this work should be kept up. Mr. Morrow stated that \$2500.00 annually would be necessary if what had been accomplished to date was not to be lost.

It was felt after discussion, that every member of the Society could well pay 25 cents a month, or three dollars a year to keep up this work.

For the information of those who might be tempted to form a hasty judgment that such an increase in dues was excessive or detrimental the following facts were presented:—

Some years ago, with very limited membership and low dues of five dollars a year (but no malpractice defense) so many members became financially delinquent that it was necessary to almost constantly have a collector at 25 per cent. commission, on the work of trying to collect these dues.

In recent years with malpractice defense, collection bureau outfits, copies of Nostrums and Quackery, refreshments at meetings, etc., the dues have been collected without one penny being spent for commissions.

In other words, as the members of the Association received increasing material benefits from the Society, they have been glad to pay increasing dues.

Let us enumerate some of these material benefits, to note whether or not every member is not actually receiving a great deal more than he pays for in cash, in the way of dues.

The malpractice feature of the State Society alone is itself worth the cost of a malpractice defense policy in a private company, i.e., is worth the fifteen dollars which such a private company would charge for such a policy.

This being the case every other item given by County Society Membership is virtually a gratis advantage.

A statement of values would be somewhat as follows:

A. Money Value Advantages.

- | | |
|---|---------|
| 1. State Society Malpractice Defense, money value | \$15.00 |
| (This State Malpractice defense is as good or better than that purchased from private companies for the above sum.) | |
| 2. State Medical Journal, money value..... | 1.00 |
| 3. State Medical Directory, money value..... | 1.00 |
| 4. Collection Bureau Outfits, money value in stores | 2.00 |
| 5. Copies of New and Non-Official Remedies, Bulletins, etc..... | 1.00 |

Total of money values.....\$20.00

B. Professional Value Advantages.

- Membership in the County Medical Society of Ethical Practitioners, with privilege of participation in scientific and social meetings. (Value what you yourself would think such permission worth, if it were not possible for you to join.)
- Membership in the State Medical Society.

(Here also the value depends upon how the individual looks upon such membership.)

8. Eligibility to Membership in the American Medical Association. (No physician is admitted to the A. M. A. unless he be first esteemed worthy of membership in the county unit by his local colleagues. What is this privilege and membership, with the copy of the Journal of the A. M. A., worth to you?)

In addition to the above it is the purpose when the medical building at Sixth and Olive Streets is completed, to maintain a library, museum and recreation rooms for members of the Association. Will this be worth anything to you?

At the same time you will have the right, by virtue of being a member in the County Society of taking offices in this building (the only "Class A" building in the city where Science healers and practitioners of what not, will be prohibited from having offices). Will this be worth anything to you?

Surely, with such an array of money value and of professional value benefits, and with the great need of keeping up the work of prosecution of illegal and vicious practitioners, this extra twenty-five cents a month will work no serious hardship on any member.

An earnest plea is made therefore by the Board of Councilors and by many members, that the increase of dues by the sum of three dollars or fifteen dollars in all, be ratified.

REPORT OF THE SECRETARY-TREASURER FOR THE FISCAL YEAR ENDING DECEMBER 19, 1912.

To the Members of the Los Angeles County Medical Association:

Your Secretary-Treasurer begs leave to submit the following report for the forty-second year of the Association, ending December 19, 1912.

Part I. Financial Report. (Report of the Treasurer).

The Financial Report of the Association is as follows:

A. Maintenance, Income and Expenses.

- | | |
|--|-----------|
| 1. The balance from last year was..... | \$ 181.29 |
| 2. The total income from 598 active and 2 honorary members, some of whom paid only for one half year, was.... | \$6990.00 |
| 3. In addition there was miscellaneous income, to total..... | 45.17 |
| 4. These three items together making a total of | \$7216.46 |
| 5. The first expense of this year was paid by check No. 1 and the last by check No. 172, and the total checked out was | 6059.85 |
| 6. Leaving a balance in the Treasury at the date of this annual meeting of.. | 1156.61 |
| 7. Subtracting the sum of \$1000.00 to be transferred to the Permanent Quarters Fund | 1000.00 |
| 8. Leaves a cash balance on hand on January 1st, 1913, of..... | \$ 156.61 |

The expenses sub-divided into their major groups are as follows:

Itemized Maintenance Income and Expenses. Income.

- | | |
|---|-----------|
| 1. Received from dues in 1912 (567 members at \$12 and 31 members at \$6).... | \$6990.00 |
| 2. Received from miscellaneous..... | 45.17 |
| 3. Carried over, balance from 1911..... | 181.29 |
| 4. Grand total of all income in 1912..... | 7216.46 |

Expenses.

1. Paid assessments to State Society (Four Dollars for each member).....\$2400.00
2. Paid for rent of hall..... 180.00
3. Paid for refreshments at meetings.... 549.00
4. Paid for clerical expenses..... 617.44
5. Paid for printing and postage..... 1096.94
6. Paid for special expenses..... 1143.75

Subdivided.

Tellers	\$ 20.00
Prosecuting Illegal Practitioners....	360.00
Owens Bill Bulletins (Printing and Postage)	453.90
Copies New and Non-Official Remedies	117.20
H. T. Morrow, State Meeting attendance	23.50
Pomona Branch	23.00
Pasadena Branch	54.00
Public Health Moving Picture Films	92.15

\$1143.75

7. Paid for miscellaneous expenses (black-board, stereopticon, etc.).....\$ 72.72
8. Grand total of all expenses in 1912.. 6059.85

B. Building Fund Assets.

A total of \$9,677.71 has been credited to the Permanent Quarters Fund. (See Report of that Committee for detailed information.)

Respectfully submitted,
GEORGE H. KRESS, Treasurer.

Part II. General Report. (Report of Secretary.)

The year just closed has been characterized by steady, forward progress, the most notable fact being the continued increase in membership, and the inauguration of the medical office building proposition.

Membership. The total number of members for whom we paid assessments to our State Society was six hundred.

It will not be out of place to again give here, as a matter of record, the total membership of our Association during the last several years.

In year 1905 total membership was 315 members.

In year 1906 total membership was 359 members, gain, 44 members.

In year 1907 total membership was 393 members, gain, 34 members.

In year 1908 total membership was 398 members, gain, 5 members.

In year 1909 total membership was 402 members, gain, 4 members.

In year 1910 total membership was 457 members, gain, 53 members.

In year 1911 total membership was 561 members, gain, 104 members.

In year 1912 total membership is 600 members, gain, 39 members.

It is evident from the above figures that the Association is continuing its steady progress as regards increase of its membership.

Largest County Society in California. The year 1912 easily makes our organization the largest county society in California, for under date of December 9th, the State Secretary informed us that the total membership of the San Francisco County Society was 554, whereas our records show that we have paid assessments to the State Association for exactly six hundred members, showing that the Los Angeles County Association exceeds the San Francisco County Society in paid up State membership by 46 members.

Campaign for New Members in 1913. This is perhaps the proper place to speak of the matter of new members for our Association. Our Society is

in hearty accord with State President Hamlin's recent letter, printed in the December 6th Bulletin and in the December 1912 State Journal, calling attention to the importance of making membership in every county medical society stand as a real indication of professional qualification and ethical dealing. The Los Angeles County Medical Association desires applications only from such qualified and ethical practitioners, and if there be within its membership any to whom are repugnant the ethical and professional principles which our Society supports, then any and all such are respectfully solicited by the Board of Councilors to discontinue their membership in the Los Angeles County Medical Association.

Our Association is strong enough to desire only loyal members who are willing and glad to live up to the true ideals of the profession and of the National, State and County Units.

We should not interpret, however, our steady increase in membership as a reason for not continuing to have those who are properly qualified, join with us in support of the principles for which we stand. We should not, in fact, rest satisfied until every eligible physician and surgeon within Los Angeles County has been given an opportunity to express his desire to become a member of the Los Angeles County Medical Association. We lay special effort on this point, because the proper time to seek new members is at the beginning of the fiscal year, January 1st.

Therefore, when you receive one of the application blanks in January, take down your 1912 State Medical Directory which you received a few days ago and run over the list of physicians in Los Angeles County whose names are printed in light type, to see whether you do not know one or more who are eligible to membership. Then give or mail your application to such physician. If you need more blanks, notify the Secretary and he will be glad to send you same.

If every member would do this several times a year, it would only be a comparatively short time until most of the eligible practitioners of the community would be members of our County Unit. In union there is strength. Every additional good member whom we add to our Association makes us just that much stronger. Let us not forget this fact.

Each member has another responsibility in regard to new members and that is to scan the list of applicants as they appear in the Bulletin and to notify the Membership Committee or officers when by any chance the name of an undesirable applicant appears. It is a very simple matter for the Board of Councilors to act properly, if it has at hand the information to justify adverse action. No publicity or embarrassment need be attached to your protest.

Members Dropped for Non-Payment of Dues. During the year just closed a total of 17 members were dropped for non-payment of dues. (Thirteen for no dues and four for partial dues.) This is not any more surprising than that a limited number of physicians in every community steadfastly refuse to affiliate with their County Units. We take it that a portion of these members who were dropped for non-payment of dues owe their delinquency to a certain kind of carelessness and procrastination. We are sorry in a sense, to lose them, but if they can not feel that the State malpractice defense, the State Journal and State Medical Directory, the membership in State and County Societies, and other advantages given them are not worth the small price of our dues, then it is just as well perhaps that they should have let their membership lapse.

Scientific Meetings. During the year meetings have been regularly held by the Los Angeles city branch on the first and third Fridays and more recently on the first and third Thursdays of each month (except during the summer months). The

attendance has been uniformly good and the informal luncheons have added much to the pleasure of the meetings. Even though these luncheons mean considerable expense, we are certain they are one of the best features recently inaugurated, for through them an opportunity is given for the formation of those new acquaintances and friendships that make so greatly for real solidarity and strength in our County Unit. Only through the cultivation of this spirit, in a large and growing Society such as ours, is it possible to have thorough good feeling and generous loyalty to the best interest of the organization.

Branches. Our Eye, Ear, Nose and Throat Branch and the Pasadena, Pomona, Santa Monica Bay and Long Beach branches all report progress. It would seem that the members about San Pedro Bay, and also in the foothill region about Monrovia, might get together and discuss whether or not it might not help the professional good spirit of their respective regions, were branches to be formed in their districts.

Personally we also believe that the Clinical and Pathological Society of our city might well become a Pathological Branch of our Society, somewhat under the same conditions as our Eye, Ear, Nose and Throat Branch. Certainly from the standpoint of broadest interest to organized medicine such an affiliation is greatly to be desired. The best is none too good for the Los Angeles County Medical Association and if the Clinical and Pathological Society of Los Angeles has aught which the County Unit has not, then the members of the Clinical and Pathological Society owe it to the County Unit which represents them and defends them, to give to that Unit of their very best. There is no reason why the Clinical and Pathological Society need in any way lose its integrity or by-laws or methods by becoming such a branch. We trust the members of that Pathological Society will give this matter their attention during the coming year.

The Bulletin. During the last year the same general method was pursued with our Bulletin as in the previous two years. It has been the aim of your secretary to present in the Bulletin those matters and that information that would work for the upbuilding of our Society. In this as in other features inaugurated in the last several years, the best indication of success is the steady onward march of our Society in increased membership and greater solidarity in feeling and action, as contrasted to the steady stationary condition of our unit, before those measures were inaugurated. Moreover, we must remember that only a minority of our members turn out at meetings and the Bulletin is the means by which other members are kept in touch with our work.

Scientific Programs. We are a believer in the principle that the Society is getting in the way of scientific programs just what it deserves. Personally, the secretary thanks all who have aided him in the last year by presenting papers, and he would state to any who thinks that the programs could be improved upon, that an invitation has been extended time and again and is, now again extended, to every member to write a paper or be responsible for a symposium for the entire evening. This being the case, it is with exceeding poor grace that any member or members should complain of our scientific programs. Let those who want better papers make examples by themselves writing better papers. Until they do this, they have no basis for complaint. Personally, we believe the papers presented to the Society have been excellent and we thank again all those who have aided the secretary by agreeing to participate in the scientific programs.

Collection Bureau Outfits. In the meeting of the State Society in April last we persuaded the State Board of Councilors to print our sticker collection

slips and offer the same to members of our Society. The State Journal contained full information in regard to this. In addition, our own Society will this week send out gratis to every member a set of 25 sheets, containing in all 175 individual follow-up stickers.

Roster of Membership. The 1912 roster of membership was printed in April last. An attempt will be made to print our 1913 roster in January next.

Owen's Bill Bulletin. In addition to the large number of Owen's Bill Bulletins sent out last Fall, many thousand were sent out last Spring also. We have the satisfaction of knowing that the thousands of copies of these 50-page bulletins which were mailed to the members of the medical, the legal and the ministerial professions of California and to the nurses' associations and women's clubs of Los Angeles, helped greatly in public health education, concerning the Owen's bill, the physical inspection of school children, etc. This pioneer public health work by our County Unit cannot fail to be of ultimate good result.

Copies of New and Non-Official Remedies. A copy of the A. M. A. booklet of New and Non-Official Remedies was purchased by the Association and sent gratis to every member of the society.

Copies of Code of Ethics. A copy of the revised code of ethics is now being sent to every County member who is not a member of the A. M. A. Members of the A. M. A. will receive their copies direct from that organization when they pay their 1913 membership fees.

Support of the Work of Prosecution of Illegal Practitioners. To help in the prosecution of the illegal practitioners practicing in Los Angeles County, the Board of Councilors voted sixty dollars monthly for six months, or three hundred and sixty dollars in all, for the use of the State Board Attorney, Mr. Hubert Morrow. Through Mr. Morrow's efforts, many of the illegal and vicious practitioners of the county were made to stop their business. This donation of \$360.00 was in fact one of the very best investments in the work of protection of the public health which our Society has made in years.

Public Health Moving Picture Films. In conjunction with the Los Angeles Society for the Study and Prevention of Tuberculosis our Association arranged for the exhibition of public health moving picture films in the public schools and moving picture theatres. Our share of the expense for this purpose amounted to \$92.15. It is to be regretted that the School Board should have subsequently thrown so many restrictions about this work that it was necessary to give it up.

Malpractice Defense by the State Society. The State Medical Association has been under very heavy expense defending the suits entered against our members in the Los Angeles County. In this day of ingratitude and specious reasoning of many citizens on public health matters, it is in the air to assail the members of the regular profession as much as possible. Malpractice suits have therefore become more numerous than ever before.

Let us be grateful that through the State Society we are able to present a united front to those ingrates and blackmailers who unjustly assail our members. Here as in few other material ways, we have another indication of how greatly our united effort is demanded to give battle to those who maliciously or fanatically would assail us.

Medical Building Proposition. The most important event in the past year was the development from a hope into beginning reality, of our "A Home for the Los Angeles County Medical Association" propaganda.

From the time your present Secretary assumed the duties of that office, the thought has been con-

stantly kept in mind that the thing that would really make his work worth while, would be a home for the Association. To that end the Bulletin was enlarged, refreshments were added to the meetings, collection slips instituted, campaigns for new members vigorously carried on and other measures inaugurated which had as their object a larger and more united membership in the Society, in the hope that from this larger and better union there might come into being a home for the Society. The finances of the A. M. A. meeting were handled by the entertainment committee with the same ultimate object in mind, namely, to give the visiting A. M. A. members the best entertainment they had ever received anywhere, but at the same time to have left over a goodly sum as a nest egg for a permanent building fund. Those plans did not go amiss, and after the A. M. A. meeting it was possible to turn over to the newly instituted Board of Permanent Quarters the sum of almost nine thousand dollars.

The question then arose as to what plan would benefit the Association most: To invest this newly acquired money as money at a five per cent. interest rate or to try to bring into existence at least a beginning home of the County Medical Association in the hope that it would pave the way for something better. One of our members having volunteered to pay part of the expenses of the erection of an addition to the Barlow Medical Library, a post card vote was taken on that plan, with a majority in favor thereof. Before anything definite was done, however, Dr. J. Rollin French appeared before the Board of Permanent Quarters and stated his willingness to undertake a preliminary canvass on the practicability of our County Medical Association taking upon itself the erection of an office building for the exclusive use of the members of the Association.

The Board of Permanent Quarters appointed a committee of which Dr. French was chairman, to undertake this canvass, and the hearty response and approval of the plan showed that we had at last arrived at that state of solidarity where so important a project might be seriously contemplated. As is often the case in matters of this kind, it was necessary to move rapidly if we were to secure the one site which all were agreed upon as being the best location, namely, the large lot at the southeast corner of Sixth and Olive streets. The Board of Permanent Quarters, by authority from the Board of Councilors, thereupon took an option on this property in the name of the Los Angeles County Medical Association.

As the purchase of this lot and the erection thereon of an eleven-story Class A office building meant an expenditure of almost one and a half million of dollars, it at once became evident that so large a proposition would of necessity have to be handled by a separate corporation and to that end the Medical Building Corporation was formed.

That corporation through a board of fifteen directors at once took up the work of organization, so that the option put up by our County Society might not be lost; and in order to place the enterprise on the safest possible basis engaged Mr. E. B. Spencer, an experienced architect, builder and banker to become the vice-president and manager of the corporation. Mr. Spencer has been giving his entire energy to making this enterprise a big success and there is no good reason why it should not become such.

As has been stated in the Bulletin, resolutions were presented by the Secretary and passed by the Board of Councilors, which obligate the Medical Building Corporation as part of its purchase price of the option originally taken and held by the Los Angeles County Medical Association, to give to that Association, desirable auditorium, office, library, museum and recreation room facilities at the nominal cost of one hundred dollars a year

rental. So that to that extent at least a splendid home is assured for our Association and its members.

The whole matter has gone too far forward, ever to permit us to go back. The building can and will be built, and along the lines outlined in the past. There can be no doubt as to its being a financial success for those who invest therein and at the same time a credit and benefit to both the Los Angeles County Medical Association and the community at large.

The only point in doubt is the extent to which the Los Angeles County Medical Association will ultimately become an actual owner of a large part of the building. If we had the whole-hearted financial and other co-operation which this enterprise deserves, it would be possible in the course of twenty-five years or so, to make the Los Angeles County Medical Association one of the richest county units in the United States. Of course, to secure such beneficial results for the future would mean that we of to-day would have to be generous enough to be willing to go to the front. And yet, many, if not the majority of our members expect to be in practice a quarter of a century hence. What we do, therefore, we do largely for ourselves after all.

When lending co-operation in this enterprise means nothing more than the safe investment of some money in the securities of a very high-class building proposition, surely under such conditions, what is demanded in the way of co-operation would not seem to be excessive.

It is the hope of many in our Association to see our County Unit become one of the strongest in America. Surely in no other community does the opposition to regular medicine seem to be so closely united in its efforts to misrepresent it and what its members stand for.

If we do not unite what will be the result at the end of a few years? What chance would we have as individuals against the rampant agitators and faddists and fanatics who have been trying to undo, and not altogether unsuccessfully, so much of our past work in the protection of the public health?

What better means can we bring into existence for continued growth and solidarity of our county unit than this medical building? Your Secretary, who has not hesitated to stand sponsor for many of the innovations during the last few years, which seem to have been so important in increasing the size and strength of our Society, tells you frankly that in his opinion, the next logical step forward is and must be a suitable home for our Society. And nothing could be better in this direction than the Splendid Class A office building which is contemplated.

Without such a home, our Society has nothing more ahead of it, other than that which was ahead of it in the past. In other words, without a home for our Association, we would have a loosely organized Society, with transient and varying spurts of activity or inactivity according as we elected from time to time, working and non-working groups of officers.

When we look about us in this city and note what has been accomplished by women's clubs and similar organizations, with far less reason for real union than our profession needs, we surely have little to be proud of as regards our own past efforts in similar directions.

Your Secretary believes with those members who hold that this building marks the eve of a better condition of affairs for all of us and that through it, we will at last, be able to come into our own. Moreover, that they who are not with the Society in this proposition must be classed among those who are against it, and against the best interests of our Association.

This is no time to quibble over theories or ideals.

We have done that for forty years and the sum total in material resources was represented by a grand saving of eight hundred dollars, or a net saving of twenty dollars a year, and the Society no stronger at the end of that time than in the beginning.

In one year more we added almost nine thousand dollars and if all of the members of this Society come forward in anything like the fashion many of them are able to, it will be possible to state within a few years that the Los Angeles County Medical Association is a wealthy county unit, active not only in the protection of the public health, but in the highest and best interests of every member of the profession and Society. But that splendid result can come about only through the generous and at the same time profitable co-operation of all its members, by taking bonds in this medical building.

It may be said that there should not be many Los Angeles city members of our Association who have not taken at least one one hundred dollar bond in this building. The terms of payment are easy and virtually within the means of all or nearly all of our members. If our Building Corporation were able to announce that every Los Angeles city member had taken at least one bond (which carries one share of stock gratis), it would make the subsequent steps in the financing of the building just that much easier and quicker. Both the moral and physical support of every member is needed and the Society has a just claim for such support in this matter.

With whole-hearted co-operation it will be possible to accomplish no end of good for our Association, but if only luke warm support is given, we will have little more than the empty thought of what might have been, to console us.

We repeat, unless unforeseen obstacles intervene, this building will be built; but whether or not it will in time become in large part the direct property of the Los Angeles County Medical Association will depend greatly on the attitude our members take in this enterprise to-day. And to-day means to-day and not five years from now.

The officers of the Association and of the Medical Corporation make an earnest plea for the co-operation of every member of the Society in this proposition and we would be false to what we have been working for in the last several years and to what we hope our Association will be able to accomplish through this enterprise, did we not emphasize in most outspoken manner our belief in the full necessity of such co-operation.

If groups of boys in college fraternities can build expensive chapter houses, and clubs of women can become owners of splendid club house property, then surely, an organization of six hundred physicians, with a history of forty years of honorable service should also be able to do as much or more.

In conclusion, we wish to thank all who in the past year have given aid in the preparation of the programs or in the work of the Society; and if there be any who feel that the Secretary was not as sweet tempered at all times as he might have been, we ask that his failure in this be put down as one of those weaknesses which beset these human minds and bodies of most if not all of us.

Respectfully submitted,

GEORGE H. KRESS, Secretary-Treasurer,
1912.

REPORT OF BOARD ON PERMANENT QUARTERS.

Mr. President and Members of the Los Angeles County Medical Association:

The first annual report of this Board was printed in the Bulletin of January 5, 1912, and showed a balance on hand of \$9,677.61.

Of the above amount \$819.72 represented the savings of our Society up to the time of the

Los Angeles meeting of the A. M. A. in 1911, and the balance of \$8,857.89 was what was left of the entertainment fund when all the debts of the A. M. A. meeting had been paid.

During this last year, as you all know, the matter of an office building for the members of our Association took on definite form.

To secure for our Association a home of its own was the reason your A. M. A. Committee did not spend all the money it collected for entertainment. That was why we spent so much effort in inducing the Chamber of Commerce to stand the expense of the Catalina trip, and Mr. Busch to bear the burden of entertaining the A. M. A. in his sunken gardens. Had we not been able to secure this generous co-operation by friends outside our own profession, then every dollar we raised would have been more than eaten up by the entertainment we were in honor bound to provide.

It was in the hope, therefore, that there would be balance remaining, that the A. M. A. Committee provided in the subscription blanks, that any balance in the A. M. A. fund should go into a separate fund known as the "Permanent Quarter Fund."

It is not necessary at this time to go into details concerning our medical building proposition. Suffice it to say, the opportunity for action, to secure a most desirable lot came before us and had to be decided yes or no, with promptness.

The Board of Permanent Quarters, after careful consideration and with the consent of the Board of Councilors, purchased in the name of the Los Angeles County Medical Association, an option on the splendidly located lot at the southeast corner of Sixth and Olive streets owned by Mr. H. W. Spiers.

Later on the County Society sold this option to the Medical Building Corporation under certain conditions as to provisions for auditorium, museum, club room facilities, etc., at a nominal rental of one hundred dollars a year.

For the money used from the Board of Permanent Quarters' Fund, our County Medical Association will receive securities of the Medical Building Corporation.

The exact amount of the securities to be received, will be determined later and will depend somewhat on how the members of the Association come through in the purchase of stock and bonds of the Medical Building Corporation.

If the members of our County Medical Association will subscribe liberally, so that it will not be necessary to use up most of the stock for an underwriting syndicate of laymen, then it will be possible to give to the Los Angeles County Medical Association an amount of securities, which, while in no way jeopardizing the good investment features of other stockholders, would, at the same time, permit our County Medical Association to become known as one of the wealthiest and most prosperous county medical societies in the United States.

The Board of Permanent Quarters therefore makes an appeal to each and every member of the Association to lend a hand in what can be made and what we hope will be, the biggest and most successful enterprise our Society has ever undertaken.

Respectfully submitted,

H. BERT. ELLIS, Chairman,
Board of Permanent Quarters.

REPORT OF THE COMMITTEE ON MEMBERSHIP.

Los Angeles, Cal., December 17, 1912.

To the President and Members of the Los Angeles County Medical Society, Los Angeles, Cal.

Gentlemen:

We, as your Committee on Membership, respectfully submit the following report:

There were forty-five applications for membership

made during the last year, six of which were rejected.

In the past, some of the rejected applicants were recommended by prominent members of the Society. This is in consequence of members endorsing applicants that they have not carefully investigated, showing that they have been careless, or indifferent, to the interest of the Society.

Any members having objections to any applicant for membership are urged to make such objections known, in confidence, to the Committee on Membership, and the same will be treated as confidential.

Very respectfully,

L. M. POWERS,
J. C. FERBERT,
W. R. MOLONY.

REPORT OF THE CERTIFIED MILK COMMISSION.

The financial income to this Commission from the Arden Dairy was \$824.02 and the expense of inspection was \$361.20, leaving a balance on hand of \$482.82.

The Medical Milk Commission have had less difficulty in getting the bacteriological counts down this year. There have been very few times when the counts have gone beyond 10,000 per C. C. We feel that the improvement in that direction has been largely due to the proper sterilizing of bottles. There have been complaints at various times relative to dirty looking bottles or sediment in the bottles. An effort has always been made to look up the cause of this careless handling of the milk and the trouble corrected immediately.

It is questionable whether any better means of education of the laity concerning clean milk, could be used than to issue a booklet setting forth the conditions in and around unclean dairies and contrasting these conditions with those of a modern, well-equipped, sanitary dairy. The results of the recent effort of the Los Angeles Health Department to secure pure milk for Los Angeles shows that an educational campaign must be started to educate its citizens along this line.

There have been several dairies which have signified their intention of starting a certified milk dairy, but as yet none have come up to the requirements, and at the present time we have one dairy which has added to its herd and has materially increased its output during the past year.

Respectfully submitted,

FITCH C. E. MATTISON, Chairman.
December 19, 1912.

REPORT OF THE MEDICO-LEGAL (Ethics) COMMITTEE.

To the Board of Councilors of the Los Angeles County Medical Society.

Gentlemen:

The Medico-Legal Committee begs leave to report that the year 1912 has been a very satisfactory one. Nine or ten cases were reported to the committee, and many of these were trivial in nature. There were very few charges preferred against any of the members of the Society. There were no suspensions and only one censure.

Respectfully submitted,

W. T. MCARTHUR,
Chairman Medico-Legal Committee.

REPORT OF PROSECUTION OF ILLEGAL PRACTITIONERS.

Los Angeles, Cal., December 19, 1912.

Mr. Chairman, Ladies and Gentlemen of the Los Angeles County Medical Association:

Your program is extensive, and your Secretary

having asked me for a brief report, I shall detain you but a few moments.

One year ago I addressed you, and most of the things we then hoped to do have been accomplished. In two years' work in Southern California alone approximately two hundred unlicensed practitioners have been closed up and put out of business, eighty-two in the period from April 15, 1912, to August 3, 1912. Professional abortionists have in large numbers been driven from the city, convicted, placed under indictment or put entirely out of business. My definition of a professional abortionist is, one who performs criminal abortions to the exclusion of all other work. Such men here are now relics of the past, though, of course, abortions are still performed. The death rate from abortions has been greatly reduced, all of the most dangerous men closed up or punished, and I leave to your collective wisdom the future problem as it applies to the other class of abortionists.

We have in Los Angeles now a separate office, a medical inspector, an attorney (not myself), but are greatly handicapped for necessary funds. The little organization is keen and effective, willing, overworked, and underpaid. That organization has the assistance of all governmental agencies and is prepared to do most efficient work. The Public Welfare League saved the day for the work, enabling us to cover, in a measure, all of Southern California. The League advances about \$75.00 a month towards the Board's work. Some of you have not joined the Public Welfare League, and many who did join, especially those amongst you who are near-millionaires, have not paid your subscription.

I have talked to members of your profession at Del Monte once, Oakland once, Fresno once, Redlands once, Riverside twice, Los Angeles now three times and Pomona once. This at the request of physicians who evidently wanted to know something of what we were trying to do. By the large amount of information which has come in from physicians since the agitation it is apparent that wider interest is being taken in these questions. At the meeting in Oakland twenty-four men immediately guaranteed sufficient money to carry on two years' work. The work is being done there by and through the County Society, and they are paying their inspector nearly twice as much as your inspector is being paid here. The results in Alameda County have been as good, if not better, than the results attained here in our first few months' work, fourteen hundred dollars in fines, I understand, having already been collected, crooks indicted, and much of the medical scum of the earth run out of the town. As an illustration of the efficiency of the present local work, due entirely to organization, and not to any brilliancy on the part of our underpaid and sometimes unpaid employees, the "Mayo Brothers," licensed physicians, masquerading under that false name, opened up an office and advertised in San Diego. In just a few days our men had them closed up there, followed them to Santa Monica where they opened up as "La Fave," and moved them out of there in about the same length of time. When we started this work two years ago it would have been practically impossible to have done anything with such an outfit.

The promise I made you a year ago to donate without compensation this year to the supervision of the work has been fulfilled, and after I have finished helping you through your coming fight in the Legislature, I shall turn over to you the burden of seeing that the organization we have here shall be enabled to continue its effective work.

If I may plead with you, let me emphasize your duty to see that all our good work is not undone by your failure to grasp the problem and provide now for continual and uninterrupted work along these lines.

As I have handled many malpractice suits and similar matters in this district for your Society, as well as taking an interest in the above matters, I have necessarily arrived at some decided notions and have drawn some conclusions from my connection with your profession. I may be transgressing on your hospitality to volunteer my opinions, but briefly the more important conclusions are as follows:

1. Educate the public regarding the noble efforts being made by your profession to benefit mankind and regarding the wonderful strides you are making. Eliminate, if possible, the unjustified ridicule of physicians on the stage or in the newspapers or magazines.

2. Raise sufficient funds to, year after year, have a young lawyer and an inspector steadily employed and with sufficient assistants to keep unlicensed practitioners and crooks down to the lowest possible point.

3. Keep on, as you have in the past, raising the standard of education and efficiency in your profession. While the law requires but ordinary care and skill on the part of the physician or surgeon, the patient always expects and should have the benefit of extraordinary care and skill.

4. See that your state organization reflects accurately the views and desires of a controlling majority of your members.

5. Make some particular study of the cause for so many malpractice suits and the means to be taken to avoid them. They have considerable bearing on the question of confidence of the public in the medical profession.

A great many things remain to be done, and I wish it were possible for me to be with you to see that they are done. I have grave fears that you will not take sufficient interest to insure consistent, efficient and continued action in assisting the Medical Board in the premises. However, as has been said of me, I have done a lot of talking; and if I have not succeeded in sufficiently rousing the profession along these lines, the fault does not lie with me. The credit for the excellent work done throughout the whole state lies with Chas. L. Tisdale especially, and with the excellent Board of Medical Examiners of which he is Secretary.

I shall sever active connection with this branch of the work, which has necessarily been a heavy burden to me, with a feeling of great respect and admiration for your members, for your efficiency and professional skill, and with intimate appreciation of your difficulties.

Respectfully submitted,

H. T. MORROW,

Attorney for the Committee in charge of Prosecution of Illegal Practitioners.

Apropos of the proposed Los Angeles County Medical Society Building, on which it is hoped to begin construction this spring, the following photograph and comments from the Bulletin of the Society, may not be without interest:

THE LOS ANGELES COUNTY MEDICAL ASSOCIATION BUILDING.

The Future Home of the Los Angeles County Medical Association.

Fronts on Sixth Street and Olive Street and is lighted in the rear by the alley, running east from Olive.

Will have the following incomparable advantages:

1. A building limited to tenants who are ethical physicians and surgeons (not like your present office building, in which you probably have as

neighbors a goodly number of so-called practitioners of mongrel forms of the healing art).

2. A fireproof Class A building, of handsome appearance, splendidly located.

3. Superheated water for sterilization and distilled ice water in every room.

4. Outlets for gas, compressed air and direct and alternating electricity.

5. Light and ventilation without stint.

6. Splendid elevator service, and entrances from both Sixth and Olive streets.



Southeast Corner Sixth and Olive Streets.
Facing Central Park.

7. An emergency operating-room.

8. A library with all the latest medical journals.

9. Smoking, reading, game and rest rooms for your noon hour.

10. Auditorium of the County Society in the same building.

11. Museum for pathological and other specimens. Exhibition room for ethical proprietaries and for surgical equipment, etc.

12. High-grade prescription drug store, surgical supply houses, nurses' bureaus, etc. in the same building.

Is there anything more that can be asked for? If so, let us know and an attempt will be made to arrange for it.

Members of the profession who fail to take offices in this building will find that other members will suspect them of luke-warm loyalty to the County Society.

Members of the profession who fail to take offices in this building will find themselves in a small minority of those who hibernate in other buildings with off-color "healers" of all kinds and descriptions.

Every member of the L. A. County Medical Association should do two things:

A. Should subscribe for at least one bond (Price \$100.00, payable in installments, with one share of stock gratis).

B. Should make a reservation for an office.

Failure to do these two things will detract just that much from the very big success the building would be, and from the benefit which would accrue to our County Society by whole-hearted and generous co-operation.

HENRY SAYRE ORME, M. D.

Dr. Henry Sayre Orme was born at Milledgeville, Ga., on March 25, 1837, and died at Los Angeles Nov. 29, 1912. Dr. Orme attended the Oglethorpe University, from which institution he received the degree of A. B. in 1858. He then became a student in the Medical Department of the University of Virginia, and later at the University of New York, from which latter school he received the degree of M. D. in 1861. He became an assistant surgeon and subsequently surgeon in the Confederate Army, where he served from 1861 to 1865. After the war he entered private practice at Atlanta, Ga., where he remained until 1867, in which year he came to Los Angeles and remained until the time of his death. He was a member of the Los Angeles County Medical Association and one of the oldest members of the Medical Society of the State of California. He had been President of the Los Angeles County Medical Association, of the California



State Board of Health, and of the Medical Society of the State of California.

For a number of years he was professor of hygiene in the Medical Department of the University of Southern California.

Dr. Orme in the earlier years of his practice in California was one of the foremost students of Public Health and Hygiene, on which subjects he wrote a considerable number of papers. In 1876 he married Mary C. VandeGraaff. He is survived by one son. Dr. Orme's kindly, courteous, warm-hearted nature was appreciated by every one with whom he came in contact, and the older members of the State Society will not soon get over the sense of loss when they fail to see him at the meetings of the Society.

**PROCEEDINGS OF THE SAN FRANCISCO
COUNTY MEDICAL SOCIETY.**

December, 1912.

The annual dinner, at which Dr. Kugeler, Chairman of the Entertainment Committee, presided, was held on December 3d at the Hof Brau Cafe. The Christmas tree, with gifts for all members present, helped enliven the proceedings.

ANNUAL MEETING.

December 10, 1912.

Presidential address by Dudley Tait:
Fellow Members:

I wish first of all to thank you for the honor, which I esteem so highly, of having been permitted to preside at your meetings and to address you to-night.

During the past year the policy of the San

Francisco County Medical Society, as outlined by your directors, your inspiring and indefatigable Secretary and serious minded committees, had but one single aim: the strengthening of the Society as a factor in the profession as well as from the view point of the public.

Hence closer relations with the laity through the Chamber of Commerce, the judiciary, the State and the municipal educational departments, the further development of section work and the use of hospital wards for clinical meetings.

The intrinsic value of membership in the San Francisco County Medical Society has been enhanced by the recent decision of your Committee on Admissions to abandon the old policy of numerical strength for that of quality. The unquestionable logic and the certain benefits to be derived from such a policy are clearly outlined in said committee's annual report.

The one illuminating event of the past year, which marks a new era in the medical history of San Francisco, we owe to your Building Committee, ably assisted by the Secretary of the State Society, Dr. Philip Mills Jones. I refer to the San Francisco County Medical Society Building which is almost an assured fact.

The tremendous possibilities of such a building—the best in the city and under the exclusive management of the County Medical Society—its elevating influence on the profession and more particularly on every tenant of said building, the resulting prestige to the Society, all this will be discussed at length in your committee's report.

Given these ideal conditions, your library becomes indispensable, and under the direction of your erudite librarian, Dr. Eloesser, its field of usefulness will be greatly enlarged; but, following the example of universities and hospitals in cities possessing a single central library (New York, for instance) we should continue to limit ourselves strictly to the support of a working library, to the files of which members may have ready and convenient access.

Your attention is especially called to the excellent condition of your finances.

It would seem like twaddle to discuss the lodge and contract question in an annual report. The problem in question is no longer one of ethics, but an economic problem of universal scope, and the advent of hordes of European immigrants through the Panama Canal will obviously modify any solution based on the semi-luxurious conditions now prevailing in the profession on this Coast.

The profession's one-sided discussion of the lodge and contract problem has demonstrated our inability to offer a solution; consequently, as in many other problems in which the public's interests outrank those of the medical profession, we must stand aside and allow the public to determine the remedy.

The value of the majority of medical society meetings is directly proportional to the character and extent of the discussion following the reading of papers. The papers appear subsequently in print, when they may be weighed with far greater accuracy than when presented viva voce. It seems manifestly unjust to call the members together for no other purpose than to listen to the reading of the proof-sheets of their State Journal, unless provision be made for an intelligent and varied discussion of the subject-matter. Your presiding officer, therefore, strongly commends the action of your Executive Committee in requiring that all papers be posted in the library one week prior to being read before the Society.

Those inclined to curtail and even exclude criticism from our meetings should be reminded that criticism is harmful only when it is destructive; constructive criticism, no matter how trenchant, is always helpful. Critical analysis! What more

potent, more just weapon have we against the ever present pretender through whose efforts advertising talent has become an accepted substitute for scientific evidence in some quarters, the pseudo-scientific type which thrives on pre-digested extract of foreign mail, the type that dominated and stifled the progress of medicine in San Francisco 20 years ago, that succession of more or less reputable old, voluble practitioners who, having attained to place and power by accidental circumstances rather than merit, could not, would not see the truth outside their lucrative chairs and spurious shrines.

To-day the medical profession of San Francisco compares very favorably with that of the great Eastern cities. Unlike the latter, San Francisco has not given all its talent to its universities; it retains nevertheless men particularly well trained in modern medicine, men whose publications have placed them in the foremost ranks of investigators, men who have driven home the fact that the field of the practitioner may develop into a most fruitful field of scientific research and that every observing practitioner is ipso facto an investigator.

Both in the directorate and in the committees, women physicians make not only intelligent but diligent and admirably loyal colleagues. Indeed, if the degree of esprit de corps commonly exhibited by medical women were universal among men, the influence of the medical profession would be immeasurably strengthened.

The history of the California Board of Medical Examiners during the past five years has been one of rapid disintegration. The Board's lowering of both ethical and educational standards, its cessation of adequate investigation of colleges and credentials, its failure to develop what California was the first to adopt—practical tests for licensure—its concessions to organized quackery (naturopaths), and its total lack of influence on medical education could but lead to disaster. Hence, the blacklisting of this State by high standard States. When, therefore, our Legislature adds a reciprocity amendment to our medical act, we shall enjoy the doubtful privilege of exchanging courtesies with the low standard States; we shall be compelled to accept the weak, the strong will be barred. In the face of such facts serious-minded people are already asking if the Board of Medical Examiners is of sufficient value to the State and profession to justify its existence. Medical legislation in California is in a state of chaos. The apathy of the profession, coupled with the inertia and unintelligence of medical officials, easily accounts for the thoughtless and vicious legislation which has crippled California's original model law, the law of our own choice, the law written in its entirety by the medical profession. And it is but natural that the unscrupulous and illiterate should have taken and shall continue to take advantage of our blunders, blunders which have wiped out decades of cumulative efforts and may eventually prove, as in quack-ridden Germany, a serious factor in the economic, moral and hygienic conditions of the country.

We of the medical profession have violated a public trust; to shift the blame to the people is neither fair nor honest.

In a recent letter addressed to the San Francisco County Medical Society, Governor Johnson writes: "I wish that I could count upon the medical profession for aid,—I mean disinterested, non-political, and non-partisan assistance by organized societies of the profession."

No permanent benefit has come of physicians' repeated attempts to assist the judiciary in the enforcement of that section of the penal code relating to abortion. The same may be said of the sporadic raids made by the postoffice inspectors.

Keep the angel makers from your Society and

let the public, through its legislators, prohibit or proclaim the "right to abort."

The broad and liberal policy of the medical departments of our two universities augurs well for the progress of medicine on this coast. Unlike private and ecclesiastic hospitals, they welcome the medical public to their wards, operating rooms and laboratories where workers and investigators will find a scientific atmosphere, a wealth of alluring material and sincere encouragement. Our university hospitals must, to be deserving of the name, do more than give patients skilful attention and careful nursing; they must deal with the problem of disease in its broadest aspects; they should constitute a clearing-house for our ideas, our doubts, our hopes. Were practitioners to avail themselves more consistently and systematically of these valuable privileges, much distant traveling might be avoided, fewer good men would shame their alma mater by dragging down ideals in bolstering up moribund institutions; our polyclinics, as now conducted, would no longer have any serious *raison d'être*, and neither the profession nor the public would mourn the ensuing loss of professorships in partibus.

That medicine is facing an ever increasing wave of discredit among the laity none of us can afford to ignore. The causes of said discredit are numerous, but none are more potent than our lack of knowledge and the untrustworthiness of a not inconsiderable fraction of the profession. The thinking public knows the unstable side of medicine, it is well aware of the tremendous role played by tradition, sentiment and fashion in medical and surgical therapy; it is not convinced that medical practice, in contradistinction to medical science, has kept pace with the general educational development of the masses; the public does not forget our ridiculous tergiversations in State and national legislative matters, our indecision and costly mistakes in municipal ordinances, our inability to agree upon and still less to enforce laws relating to the practice of medicine and public health. It cannot understand our failure to suppress that curse of American medicine,—the proprietary medical school; or our indifference toward the dichotomy* activities of certain operating higher ups; it cannot understand why the law governing contract and fraud should operate differently with the physician than in the case of other individuals, or the readiness of physicians to build a wall of immunity around confreres guilty of crass ignorance or inexcusable carelessness. The advanced thought of the intelligent portion of the community refuses to be fed on doctrines, it wants more than a veneer of truth, it yearns for facts, it expects more from the medical profession than mere treatment. Nevertheless, it has thought out the place of the physician in our social order and it realizes the enormous service medicine is capable of rendering. It, therefore, behooves the physician to regain the public confidence; and we ought to make haste and reform ourselves from within before the storm of public disapproval becomes uncontrollable.

Let us come down from our pedestals and get closer to the people, consult more often the public pulse rather than attempt to control it, remember that medical men exist for the benefit of the public and not the public for the advantage of our profession, and that our responsibilities to the public increase in proportion to our knowledge. Let us be more frank with ourselves and make ethics synonymous with plain honesty and common sense. Let us restrain those who are lowering the practice of medicine to the level of the trades; let us recognize and encourage the superior training of the younger generation of physicians, cease belittling the role of the M. D. in the public

* Fee splitting.

eye, and refuse to employ as anesthetists, assistant school inspectors, etc., trained nurses who are neither legally nor otherwise qualified to act in such capacity.

In analyzing the public's mistrust of the M. D., let us not forget the infinitesimal percentage of our confrères we dare consult when sickness enters our own household. Let us acknowledge the crude and imperfect character of our present methods of limiting the incidence of disease, of protecting the individual or perfecting the race. Let us get closer to the fundamental sciences upon which modern medicine is based, cultivate the negation of all doctrines—the experimental method—and by dint of patient and ceaseless effort, perfect our conspicuously rudimentary and defective powers of observation. Bearing in mind le grand peut-être of Rabelais, let us curb our attitude of obstinate unreceptive skepticism, especially in regard to the role of emotion on the condition of physical health.

Above all, let us endeavor to develop a spirit of loyalty to each other, a hearty and unselfish co-operation and combination within our ranks, and working shoulder to shoulder build firm the foundation of a great professional fraternity with unquestioned ethical and ever higher educational standards. By so doing we may see, as in certain European countries, an enlightened public turn to their physicians as guides, philosophers and friends, both in health and disease.

Happy the one who can say to himself when the curfew of life glitters upon the evening air,—“I have done what I could” for the cause of the profession and the welfare of humanity!

Report of Secretary-Treasurer.

Mr. President and Members of the Society:

As Secretary I beg leave to submit the following report for the year 1912, that is from December 10th, 1911 to December 10th, 1912, inclusive:

Number of members in Society Dec. 10, 1911.....	548
New members admitted.....	36
Resigned.....	4
Transferred to other county societies.....	2
Died.....	5
Expelled.....	1
Dropped for non-payment of dues.....	10
On leave of absence.....	6
Number of members in Society Dec. 10, 1912.....	556

(This does not include four to be admitted this evening on recommendation of Admissions Committee.)

It will be noted that we have eight more members in good standing at this time than last year. The question of the collection of dues is still a perplexing one. As stated in last year's report, in spite of continued efforts on our part, it is most difficult to make members understand that dues are payable in advance and not at the end of the year. An amendment was this year introduced so as to emphasize the importance of payment of dues semi-annually in advance. We are now introducing an amendment which we hope will be effectual in compelling members to pay their dues annually in advance, that is, on January 2 of every year. This should simplify the work of our office, and all members whose dues are not paid by March 1st will be dropped. We have this year dropped a considerable number of members, as you have heard, thus retaining insofar as possible only members who are prompt in the payment of their bills. We still have 13 members on our list, owing us \$165.75, all of whom have been retained because of special pleas that they have made, or because of promises to pay on or before a certain definite date. In all probability these 13 names will adorn our January program, in the column of “Members dropped for non-payment of dues.” It is surprising that this list should include men connected with large hospital associations, as well as holders of municipal offices. We have another list of 51 members who owe the

Society a total of \$301. If these members have not paid by the first of the year, they too will have the pleasure of seeing their names in print. It is most probable, however, that all of these 51 will pay.

Through the persistent efforts of the Librarian, Dr. Eloesser, \$126.50 was collected from members during the year, this money to be expended on the Library. The sale of duplicate journals increased this special fund, so that the Librarian was able to spend considerable in addition to the sum allotted to him by the Board of Directors, namely \$775.00.

A detailed financial statement follows:

Receipts.

Balance on hand December 10, 1911.....	\$ 863.42
Collected from members (dues and contributions to Library), rental of library and sale of bonds.....	\$12012.89
Total receipts.....	\$12876.31

Disbursements.

Rent.....	\$ 1200.00
California State Med. Soc. in lieu of exchanges.....	180.00
Salary of office assistant.....	885.00
Secretary's salary and bond.....	205.00
Laundry.....	18.00
Library (subscriptions, etc.).....	587.02
Binding.....	221.15
Printing (including envelopes and stamps for Soc. and Com.).....	469.05
Telephone.....	104.75
Committee on Necrology (flowers and engraving).....	7.00
Assessment to State Society.....	2216.00
Typewriter, desk and book racks for Lib..	122.00
Relief Fund.....	150.00
Bonds.....	4664.30
Balance on bond coupons (deposited in Sav. Union).....	15.70
Entertainment.....	204.50
Incidentals (water; safe deposit box; insurance on lib., taxes, etc.).....	140.96
	\$11390.43
Balance on hand.....	\$ 1485.88

One hundred and fifty dollars, it will be seen, was given for the relief of the destitute family of a San Francisco physician, this money being spent as per custom, by order of the Board of Directors.

Of the money which appears under the disbursement for bonds, most of this was obtained from the sale of bonds, part of the so-called “Relief Fund,” the remainder being a loan to the Relief Fund for the purchase of the bonds.

Of the above loans, all but \$150 has been repaid. Of the amount entered under expenses of the entertainment committee, \$148 was recovered from the members. An item of \$12.50 is here included, this being for the rental of chairs, made necessary by the large audience present at the Von Noorden meeting. It is possible that next year the executive committee will have to consider the purchase of additional chairs.

The Society this year purchased a typewriter and desk, the ones which we have been using having been the property of our former stenographer.

There are a number of bills totaling about \$250 for the year to be paid by the end of December, also several bills which the library has incurred and which will only be presented on the first of the year. As has been our custom, part of the latter bills are paid out of next year's budget.

It will thus be seen that with a balance of \$1485.88 cash in bank, with \$150 still due from the Relief Fund loan, and almost \$200 to be collected from men who will probably pay without much

more coercion, the Society is on an excellent financial basis. In other words, in spite of larger expenses as a result of more frequent and larger meetings, increased size of the program, after paying outstanding debts and collecting some outstanding dues, etc., we are about \$800 ahead of where we were last year.

In last year's statement, the following appeared: "The Society owns 5 San Francisco North Pacific bonds, expiring Jan. 1st, 1919; also 3 North Pacific Coast Railway bonds, expiring Jan. 1st, 1912. The accumulated interest of this fund amounted to \$1233.17 on July 1st, 1911, this money on deposit in the Savings Union Bank of San Francisco."

Sold: 5 S. F. & N. P. 5% bonds at 104....	\$5200.00
Accrued interest—1 mo. and 12 days..	29.17
	<hr/>
	\$5229.17
Less Commission	12.50
	<hr/>
	\$6216.67
Bought: 5 Spring Valley Water 4% bonds	
at 95½	\$4775.00
Accrued interest—2 mo. & 12 days	40.00
Commission	12.50
	<hr/>
	\$4827.50
5 Pacific Tel. & Tel. 5% bonds	
at 100½	\$5012.50
Accrued interest—1 mo. & 11 days	28.47
Commission	12.50
	<hr/>
	\$5053.47
	<hr/>
	\$9880.97

It will thus be seen that the Society now has in its possession 10 bonds of a practical value of \$1000 each. On January 1st \$225 will be obtained from the coupons, \$150 of which is still due the general fund of the Society. The sale of our other bonds, and the buying of new ones at a favorable time, has thus reaped a benefit for the Society of approximately \$150 to \$200, thanks to the Finance Committee.

To the chairman of the Entertainment Committee the secretary would especially like to extend his appreciation of the work done by him during the year, inasmuch as he feels that the Society does not realize the tremendous efforts necessary in the carrying out of impromptu dinners to celebrated visitors, as well as the getting up of a Christmas tree.

Respectfully submitted,
(Signed) RENÉ BINE.

Librarian's Report.

To the President and Members of the San Francisco County Medical Society.

Gentlemen:—The library has improved considerably during the past year. We have added 406 bound volumes to our files and have subscribed to 21 new journals. We have filled out the files of 24 journals by purchase and by exchange; some of these we have been able to complete, others, whose files would have been very expensive to fill out entirely we have completed for the last ten years, leaving the earlier and more expensive but less frequently called for volumes until such a time as our funds might warrant their purchase without curtailing the acquisition of books and journals of more immediate interest. We have had 235 volumes bound, our endeavor being to bind the more valuable and more frequently called for journals first; many of our files still remain to be bound, and in order to preserve them intact I recommend that next year's appropriation be made sufficient to have this done. Eye, ear, nose and throat, urological, gynecological and pediatric journals represent the greater part of the new subscriptions. Up to this year we felt ourselves able to subscribe to but very few specialistic journals,

considering that those of interest to the general practitioner should be taken first. With the division of the Society into sections, however, came demands for specialistic journals, and to these our increased budget has enabled us to accede. The library made agreements with the various sections by which they were to furnish or complete certain files of journals and systems of medicine, whereas the library was to pay for the new subscriptions. The eye, ear, nose and throat section has tried, through the librarian of the old Eye, Ear, Nose and Throat Society, Dr. Frederick, to carry out their part of the agreement, and Dr. Willard of the urological section has notified us of its willingness to do its share.

We have received cash contributions from the medical and surgical sections of \$51.00 and \$60.50 respectively, and \$15.00 for X-ray journals. With this money we bought Keen's Surgery, and subscribed to foreign archives of internal medicine, of pediatrics and X-ray.

We have cleaned the library of a quantity of duplicates, selling them at a good price to second-hand book dealers in New York and Leipzig and to the Stanford Library. The sale of these duplicates has brought us in round figures \$166.00.

The completion of our files could not have been carried out were it not for these very welcome additions to our budget.

Our budget was just sufficient to pay for the journals and their binding; our books have come to us from various sources, public and private. We are indebted to Dr. Sherman for a great number of useful surgical books, to Dr. Stelzner's widow for the books belonging to her late husband, and to several others. We owe thanks to the Society of German Physicians, which at its dissolution made over its valuable library to us, and to the State Journal, which lets us have the books sent in for review. In this connection I may mention that we will be glad to receive and acknowledge donations of modern text books and of all journals, old and new. Many of the members have books that would prove very acceptable for which they no longer have interest or use, and many of them have broken files of journals to which they no longer refer, but which might fill one of our greatly needed sets. The library would be very glad to know of such files. Furthermore, I would urge that the members show more interest in reviewing books. When we receive a book from the State Journal we send out a card to a member asking whether he will review the book. Often we get no reply, sometimes the book is taken for review, but months elapse and no review comes forth—sometimes we don't even get the book back. By good reviews and prompt ones we should get more publishers to send their recent publications in to the Journal, which is the main, almost the sole, source of our text-books.

The policy of the library has been to endeavor to provide a satisfactory working library for the general practitioner. Our budget is small, we have had to limit ourselves to this. I have tried therefore to make our files of journals of general interest, the weeklies and monthlies, particularly the domestic and the English ones, as complete as possible. There are many special journals, which we should still have. The purely scientific journals we have left aside. Our budget would not allow of any but a very scanty selection, and I have thought that the interests of the Society, i. e. of the general practitioner, would be better served by providing for the clinical side of medicine and leaving the journals of academic interest, the scientific journals, to the university libraries, whose duty it is to foster and provide for that part of the profession that is engaged in purely scientific research. In this way our files and those of the Lane Library in a measure complete each other.

In closing I would urge our two necessities on

your attention, viz., money—a liberal budget and liberal donations, and space—more ample quarters, for we have outgrown our own.

Respectfully submitted,
(Signed) LEO ELOESSER,
Librarian.

Report of the Milk Commission.

To the Members of the San Francisco County Medical Society:

Your Milk Commission has completed its seventh year of existence and its fifth year of active work. During the past year a fourth dairy, situated in Napa Valley, has been certified, and for the first time barns and complete equipment have been erected under the direction of our experts. An overhead trolley system is inaugurated to handle feed and manure; and overhead water pipes to prevent the dragging of hose over floors when in use in cleansing the animals prior to milking. The proprietor, an experienced dairyman, made this unsolicited comment: "It is easier work and takes less men to run this dairy than a commercial dairy of the same size."

A dairy at Bixler is in the process of certification, where the problem of the relation of milking machines to the bacterial content of milk will be worked out.

A new cap has been adopted for the certified milk bottles.

At the present moment there is considerable confusion in the distribution of milk due to the establishment of 7 a. m.—5 p. m. hours by the drivers in town, entailing the once a day delivery of milk. Under this arrangement, however, certified milk will reach the consumer at an earlier age.

The number of distributors has increased in San Francisco to sixteen, and the commission has appointed an inspector of distributing points, who will visit the stations and keep watch of the conditions as to icing, etc., in which milk is held. This is a new departure and your commission feels it will add much to the strength of the commission's work.

In November, the news of the death of Dr. Geo. S. Baker came to us. Dr. Baker had been on government work under the Bureau of Agriculture in the Philippines during the past year, and died at his home in Berkeley shortly after his return. He had a leave of absence from his position as a lay member of the Milk Commission for the year. Dr. Baker has given us throughout his four years of service on the commission most generously of his expert knowledge on dairy matters, and has served tirelessly on committees and dairy trips taking many hours of time. It was under his advice that we passed what is known as the 10% law, i. e., no cows may be added to a dairy herd coming from a bunch of cows which show more than 10% of reactors to the tuberculin test. This law was reported to the American Association of Medical Milk Commissions by Dr. Geo. Baker in 1910 at Philadelphia, where he represented us, and approved by them.

At present 3642 quarts of milk are sold daily under our certification in San Francisco County; 176 on the Southern Pacific Railroad, and 219 in Marin County, making a total of 4037.

Our commission, in conjunction with the Alameda County Milk Commission, has sent a delegate for the past two years to the annual meeting of the American Association of Medical Milk Commissions. This we regard of great value to us as it keeps our commission in close association with the work throughout the country.

We have received the resignation of Dr. Lewis S. Mace, who has served for four years as a member of the commission, and for one year as its president.

During the year three lectures have been given on Phases of the Milk Supply and Certified Milk, to audiences in San Rafael, the students of the University of California in a course on Civic Problems, and to the Cooper Science Club. The slides illustrating these lectures (some 40) have been loaned to the Chinese Y. M. C. A., and may be borrowed for any lecturer's use who wishes to help the appreciation of the value of pure milk.

Your commission relies on the University of California for the chemical and bacteriological as well as veterinary work at the dairies, and wishes here to thank Professor Jaffa and Dr. Roadhouse for their faithful work and constant interest.

The commission is solvent. Its income is derived from the tax of 50 cents per thousand on the caps, and this covers the expenses of assistant secretary and inspector, visits of the commission to dairies, etc.

A closer acquaintance with the working charts and records of the commission on the part of the Medical Society is greatly desired. More active co-operation by the medical profession, which would follow an understanding of what your commission is attaining, could double the sales of certified milk and reduce infant mortality and morbidity from intestinal diseases correspondingly.

Respectfully submitted,
ADELAIDE BROWN, President,
Milk Commission, S. F. Co. Medical Society.

Report of the Committee on Admissions.

Your Committee on Admissions begs to report as follows:

During the year ending with the December meeting, 40 members have been admitted into our Society. It was found necessary during this time to reject four candidates. This committee has taken the stand that, with the exception of members transferred from other county societies, it would not consider the name of any candidate for membership until he had practiced for at least six months within this city. This was found necessary in order to show a man's qualifications and attitude toward the profession and the public before hurrying him into membership. We also have rejected applicants doing contract practice for so-called "dollar a month societies." This move was actuated by the medical defense clause in our State Society's By-laws. We feel that one doing a large amount of practice for insufficient pay is more liable to be sued than others, and the sum of one dollar a year is far too little to insure such applicants. We would recommend that this point be emphasized at the next meeting of the State Society, and earnestly request that it be included in our by-laws.

Signed: GEORGE D. CULVER,
C. A. WOOD,
SHADWORTH O. BEASLEY,
W. S. FRANKLIN, Chairman.

Report of the Hospital Commission.

To the Officers and Members of the San Francisco County Medical Society.

Gentlemen:—The Hospital Commission of the San Francisco County Medical Society begs leave to submit the following report for your favorable consideration:

The following communication dated October 16th, 1912, was received by the commission:

Alexander Maternity Cottage,
3700 California St.,
San Francisco.

Dear Sirs:

Enclosed please find copy of rates for the Alexander Maternity Cottage service of the Children's Hospital.

MATERNITY RATES.

House cases, \$50.00 for two weeks' care. Price includes delivery room fee, drugs and dressings.

Private patients, \$4.00 and \$5.00 per day; delivery room fee and dressings, \$10.00; all drugs extra.

The \$50.00 rate is for house cases unable to afford a private physician. These cases will be cared for under our staff, thus giving internes and pupil nurses the opportunity for practical experience.

Will your committee kindly consider this new rating in passing on the ethical position of the Children's Hospital, as the rates at the Maternity were the basis for your former criticism?

Hoping this will meet with the favorable consideration of your honorable body and requesting that you kindly let us know the action of your committee,

Very sincerely,

(Signed) JENNIE H. DUNBAR,
General Secretary.

This new rate for house cases which is now in operation at the Alexander Maternity Cottage will be instrumental in correcting many abuses that formerly existed in the disposition of this class of patients. This arrangement is satisfactory to your commission and renders the Alexander Maternity "an approved hospital" within the meaning of the resolutions regulating the conduct of hospitals.

Dr. Rene Bine has notified the Hospital Commission of a recent interview with the president of the French Benevolent Association, in which this gentleman commented on the derogatory report of this commission concerning his institution, and he expressed a desire to discuss the issues involved. This information is very pleasing to the commission, and we shall gladly enlist the co-operation of Dr. Bine in perfecting the arrangements for such a conference.

Nothing new have developed in the relations of the German Benevolent Association and the Hospital Commission. As far as we can ascertain the gratuities of the hospital are still distributed to both classes of members, and the breach is widening between the original purposes of the organization and to-day's system of quasi-benevolence. In view of a meeting with the French Hospital authorities, and the possibility of something tangible resulting therefrom, it was deemed a matter of equity by your commission to refrain from making a final recommendatory report in the matter of the German Hospital.

Your Hospital Commission deprecates the fact that the wheels of medical reform move so slowly, but its members look forward to the coming year for the solution of many vexatious problems.

(Signed) THOMAS D. MAHER,
Chairman.

Many thanks are due the gentlemen who helped in such great measure in the evening's entertainment:

1. Quartet for piano and strings.....
.....Beethoven, Opus 16
Andante cantabile.
Rondo, allegro ma non troppo.
Dr. M. W. Fredrick, Dr. L. Eloesser, Dr. E. A. Victors, Dr. H. I. Wiel.
2. Vocal solo—
"Mother o' Mine".....B. Tours
"Gray Days".....Noel Johnson
Dr. H. S. Moore.
Dr. Wiel at the piano.
3. Quartet for piano and strings.....Mozart
Andante.
Rondo, allegro.
Dr. M. W. Fredrick, Dr. L. Eloesser, Dr. E. A. Victors, Dr. H. I. Wiel.

Section on Surgery.

December 17, 1912.

1. Recent Advances in Obstetric Pathology. Dr. L. Breitstein.

2. Exhibition of Clinical Cases:

Carcinoma of Penis; X-Ray Plates of Renal Stone; Operation for Infantile Paralysis. Dr. W. B. Coffey.

Three Cases of Poliomyelitis Paralysis. Dr. S. J. Hunkin.

Case of Chronic Multiple Arthritis (Ulcerative and Adhesive); Spindle-cell Sarcoma of Sacrum. Dr. J. Rosenstirn.

Description of an Obstetrical Indicator. Dr. H. Spiro.

DR. BEVERLEY MACMONAGLE.

Dr. Beverley MacMonagle was born in Sussex, New Brunswick, on October 19th, 1855, and graduated from Harvard University in the year 1876.

For some time after graduation he did not enjoy the rugged good health that voiced itself in his appearance and every action during his subsequent life, and on the advice of his physician he spent nearly a year with the cowboys on the cattle ranges, leading a life that not only restored his health but that, without doubt, did much to develop the self-reliance that stood him well in



the practice of his profession and made him a tower of strength to many who received his aid and sympathy.

Upon his arrival in San Francisco in 1884 he became associated with the late Dr. John Scott in the work at the California Woman's Hospital, and for many years was surgeon-in-chief of that institution, a position that put him in the forefront of gynecologists, although he did not limit himself to that specialty. For six years he was associate in the chair of Gynecology in the University of California, but resigned in 1906, a few months after the earthquake, as the destruction of the hospitals diminished the amount of clinical material to such an extent that there was not suf-

ficient to constitute two services, and at the same time his duties as gynecologist at the Hospital for Women and Sick Children required as much time as he could spare from his other work.

In the spring of 1910 he had a mild attack of aphasia from which he recovered after a few weeks, but he made up his mind that he would rest for at least two years, and even then would not resume practice unless he felt perfectly able to do so. In accordance with this resolution he went to Europe, where he enjoyed comparatively good health, spending most of his time motoring through the Continent and Great Britain, until within two weeks of his death, when he suddenly developed an acute exacerbation of a nephritic trouble from which he had suffered for two or three years. He died at the American Hospital in Paris, France, upon the 22nd day of May, 1912.

With the passing of Beverley MacMonagle the medical profession lost a member who had all the natural qualities of a leader—ability, judgment, integrity, courage, sympathy and an impressive personality. If Dr. MacMonagle undertook the responsibility of a case, he discharged his duty with equal fidelity irrespective of whether the patient were prince or pauper. His patients were his friends.

WM. WATT KERR.

DR. EMIL STELTZNER.

Dr. Emil Steltzner was born Jan. 18, 1862, in Frankfurt-on-Oder, the son of highly cultured and well-to-do parents. Receiving a broad and excellent education, his natural marvelous gift for music was cultivated, so that his musical attainments almost rivaled his scientific achievements. He studied medicine at Halle, Berlin, Bonn, and Leipzig, taking his degree at the last named university.



In 1891 he came to America and located at Alameda, from which place he moved to San Francisco in 1900.

Emil Steltzner specialized in gynecology and was known amongst his associates as a walking encyclopedia of medical literature. For many years he was the treasurer and librarian of the German Medical Society, sacrificing a great deal of time and labor in the furthering of the work of this organization.

The last two years of his life were for him

years of atrocious suffering, the result of a lymphosarcoma of the peribronchial glands. Gradually the jovial and popular man withdrew from most societies in which he formerly took an active interest and shunned everybody with the exception of a very few select friends.

His death occurred on December 12, 1911. He left a widow and a nine-year-old son.

A large number of Dr. Steltzner's valuable medical works were left to the library of the San Francisco County Medical Society.

VICTOR C. VECKI.

DR. JAMES B. HANNAH.

James B. Hannah was born in Toronto, Canada, September 21st, 1864. Here he received his preliminary education and resided until 1892, in which year he came to San Francisco. During the former part of his residence in San Francisco he



was an active member in the contracting firm of Hannah Bros. In 1898 he began the study of medicine in Cooper Medical College, graduating with the class of 1902. Since graduation he had been engaged in the practice of his profession in San Francisco.

Dr. Hannah had been for a number of years a member in good standing of the San Francisco County Medical Society. His untiring efforts to relieve human suffering are highly appreciated by his confreres and a large clientele. He stood high in the ranks of Freemasonry, having been a member of Alpha Lodge No. 384, G. R. C., since 1887, and of Antiquity Chapter No. 91 since 1889.

The cause of his demise, which occurred on July 28th, 1912, was follicular tonsillitis of forty-eight hours' duration, this latter causing an acute exacerbation of a chronic myocarditis.

Dr. Hannah is survived by his wife, four children, and a host of bereaved friends.

H. EDWARD CASTLE.

SONOMA COUNTY.

The annual meeting of the Sonoma County Medical Society was held at the offices of the President, Dr. R. M. Bonar, at Santa Rosa, on December 21, 1912.

The following officers were elected for the en-

suing year: President, Dr. Jackson Temple, Santa Rosa; vice-president, Dr. J. W. Scannell, Santa Rosa; secretary, Dr. A. R. Howard, Santa Rosa; treasurer, Dr. F. O. Pryor, Santa Rosa; censor, Dr. J. W. Seawell, Healdsburg; delegate, Dr. R. M. Bonar, Santa Rosa; alternate, Dr. J. W. Cline, Santa Rosa.

RESOLUTIONS ON THE DEATH OF DR. GEO. S. BAKER.

Whereas, Dr. George S. Baker has served on the Milk Commission of the San Francisco County Medical Society for the past four years and has given valuable aid and counsel at every point;

Whereas, This service is one to humanity and a gratuitous contribution of time and strength quite outside the lines of his professional work;

Resolved, That the Milk Commission of the San Francisco County Medical Society deeply deplores the loss of Dr. Baker's service to the Department of Agriculture, and especially the loss to our community of his wisdom and knowledge as a member of this Commission.

Resolved, That a copy of these resolutions be sent to Dr. Baker's family and that they be published in the California State Journal of Medicine.

Signed:

The Milk Commission of the San Francisco County Medical Society.

ADELAIDE BROWN, President.

E. C. FLEISCHNER, Secretary.

December 17th, 1912.

NEWS NOTES FROM NEWSPAPERS.

Susanville has a case of smallpox.

Santa Cruz county has appointed Dr. W. H. Keck health officer.

Colusa county has reappointed Dr. C. A. Poage as health officer.

Dr. McNulty has been appointed health officer of Siskiyou county.

San Jose has reappointed Dr. J. J. Kocher at the head of its health board.

The Children's Hospital, San Francisco, has just opened its new addition.

Orange county has reappointed Dr. John Wehrly as health officer for two years.

Hanford has another hospital, the Doran, which was opened for patients in January.

Shasta county has reappointed Dr. F. Stabel as health officer and hospital physician.

During 1912, 2120 physicians died in the United States, the average age being 60 years and 23 days.

The University of California Medical Department is to receive \$400,000 to build and equip an additional hospital.

Alpine county, the smallest county in the State, has not reported a single death from tuberculosis in the past five years.

The California Hospital, Los Angeles, is to begin the reconstruction of its buildings, making them all Class A buildings.

Salinas has met with a misfortune in the closing of its hospital, the Jim Bardin, which the owner reports did not pay.

Fresno county reports 86 cases of smallpox during the last year and 294 cases of contagious diseases of all sorts, mostly measles.

Dr. G. W. Burk, of Sisson, is reported to have been arrested for not complying with the law in regard to reporting contagious diseases.

Dr. H. N. Rowell has resigned as physician to the adult blind institution at Berkeley and Dr. Myra Knox has been appointed to fill his place.

A bill before the Legislature would provide for persons who are mentally sick, but not insane, and who do not really belong in an insane asylum.

At Oroville the health officer is urging a strict and drastic fight against unmuzzled dogs, for he wisely wishes to keep rabies out of his territory.

Tuberculosis caused the deaths of 23,831 persons in California during the past five years, according to figures given out by the State Board of Health.

At Vallejo a "Dr." E. M. Carpenter, a chiroprapist, was arrested recently for practicing medicine illegally; he was suspected of having performed an abortion.

The Slingsby case of baby substitution seems to be keeping its place of attractiveness in the press. It is all so melodramatic and "dimenovely" that it is probably true.

At Stockton the medical inspection of school children has proved of great value and Dr. Goodman reports that 970 children were found to be in need of medical or dental care.

The Pomona valley hospital building was destroyed by fire on December 21st, and the newspaper accounts give great credit to the heroism of the nurses in saving the patients.

Dr. Carl G. Wilson is reported to have made a charge of \$35 which the grateful patient considered too low and so sent him a check for \$1000! Would that there were more such patients.

Butte county is to be congratulated upon its health officer, Dr. L. Q. Thompson, and some day the Chico "Enterprise" will be sorry it attacked him for his work against smallpox.

At Livingston, a man by the name of Harold Sampson was recently convicted of practicing medicine illegally and sentenced to the county jail for 180 days; the sentence was suspended during good behavior.

The Stockton "Record" talks about "Medical Tyranny" because doctors object to pharmacists practicing medicine. Would the editor of the "Record" like to have his druggist take care of him in an illness?

Whooping cough is the subject of a pamphlet issued by the Public Health Service and written by our old friend Dr. Colby Rucker; the service is doing a valuable work in issuing these pamphlets on timely subjects for general distribution.

Dr. A. E. Osborne has resigned as superintendent at the Napa State Hospital and Dr. A. W. Hoisholt has been appointed from the Stockton institution to take his place. Dr. Margaret Smyth has been promoted to take Dr. Hoisholt's place at Stockton.

Berkeley is having a nice little epidemic of smallpox and one can hardly imagine a more appropriate place in which to locate such an epidemic. Berkeley has been the center of the anti-vaccination agitation for a number of years. The schools and Sunday-schools are closed.

George Gelder, attorney for Bohannon, the cancer quack, wants Berkeley to pass an ordinance to prevent physicians from spreading contagious diseases! The same erudite gentleman, who is in the Assembly, would make it a misdemeanor or a felony or something awful for anyone to require anyone else to be vaccinated.

BOOK REVIEWS

Skin Grafting. By Leonard Freeman. Quarto, cloth. Pages 129. C. V. Mosby Co., St. Louis, Publishers. Price \$1.50.

There is not much good to be said of this book. It contains nothing new; as a compilation it is incomplete, sometimes inaccurate and contains statements of opinion not at all in accord with modern teaching. Numerous references to the earlier literature will make it welcome to those interested in the historical development of the subject. The opportunity for an exposition of the many problems connected with skin grafting—absorbing ones and full of actual interest—has been let pass.

L. E.

Microbes and Toxins. By Dr. Etienne Burnet. Translated from the French by C. Broquet and W. M. Scott. Science Series, G. P. Putnam's Sons, 1912. Price \$2.00.

Burnet's aim in this book of some 300 pages is to bring the bacteriological science from the laboratory and set it before the reading public. Only those who have experienced the difficulty of putting medical science into popular form will appreciate Burnet's work. He reveals a universe of micro-organisms, some beneficent, others mischievous, upon which the science of bacteriology is founded. For the layman the first half of the book will solve many questions, as to just what germs are, their form, their mode of life and ways of invading man. For the student and practitioner no more interesting or more fascinating reading can be found than Burnet's chapters on immunity, anaphylaxis, vaccines and sera and the conquests and still unlimited possibilities of chemotherapy.

E. D. D.

A Treatise on Pellagra for the General Practitioner. By Edward Jenner Wood, S. B., M. D. Published by D. Appleton & Co., New York and London. 1912.

The general practitioner who resorts to this book for his knowledge of pellagra will find it difficult to wade through the mass of summaries, quotations, and translations which form the opening chapters on history and etiology. The book consists essentially of reading notes, unnecessarily complete and presented in many places without a clear indication of the purpose of their introduction. The chapters devoted to description of the disease are enlivened by helpful pictures and by illustrative material from the author's own experience with four hundred cases. On the basis of history and of his American experience, the author considers the maize theory of the causation of pellagra to be untenable. In describing the skin lesions he places great emphasis on their accurate symmetry and he considers this point of great diagnostic importance. While the book has many faults in style and construction, it will nevertheless justify its existence by making available the author's extensive observations on pellagra as it occurs in America.

W. A. S.

Arteriosclerosis. By Louis M. Warfield, A. B., M. D. Second edition. C. V. Mosby Co., St. Louis, 1912. Price \$2.50.

The author, addressing himself to the general practitioner, has endeavored to give a "readable authoritative essay on a disease which is especially an outcome of modern civilization." The

parts of the book most likely to accomplish this purpose are the chapters on symptoms, prognosis, and treatment of arteriosclerosis, and on its relation to life insurance, where the author speaks with the force and interest of personal experience. Many of the other chapters do not give the reader this favorable impression. They frankly consist largely of summaries or extracts from the opinions of others, which have been put together without the amount of criticism one would expect in a truly authoritative monograph. In common with too much of the literature which the practitioner is asked to read, words are not economized, and the reader who conscientiously goes over these 200 pages will feel that a small percentage of this space would have sufficed to give him all the important facts. In addition to lack of discrimination and conciseness, this defect is referable to errors of arrangement. For example, one finds discussion of auscultatory phenomena below the blood pressure cuff in three separate places. Again, blood pressure instruments are discussed on page 61 et seq. and a second time beginning on page 124. Historical comments are made in both places; in the first Marey is given credit for devising the first useful blood pressure instrument in 1876, in the second reference is made to V. Basch as having made the first one in 1887. Many other examples of defective editing might be pointed out. The remarks on the physics of blood pressure instruments are nothing short of naive.

E. S. K.

Surgery and Diseases of the Mouth and Jaws.

By Vilray Papin Blair. Quarto, cloth. Pages 638. C. V. Mosby Co., St. Louis, Publishers. Price \$5.00.

The author has combined both the dental and the surgical aspects of the diseases of the mouth and jaws in an unusually good and thorough presentation. Many good illustrations of dental deformity and disease incident to disease of the mouth and jaws, and an explicit and clear text will make the dental part of this treatise especially valuable to the general surgeon, being an aspect of the subject hitherto little considered in surgical text-books. The chapters on fractures of the mandible and on cleft palate and hare-lip are excellent; they present points of view that should be of use in preventing dental errors often made by the general surgeon in treating these conditions. To the dentist the book may be recommended as everywhere embodying sound surgical principles, and as the fruit of a wide surgical experience. Photographs of specimens from London museums, taken especially for this book, descriptions of methods witnessed at foreign hospitals, plates of casts and anatomical dissections evidence the labor and care bestowed on the work, which however is not a mere compilation, but gives plentiful expression to the author's personal opinion—the result of wide experience and of sane and critical judgment. The first few chapters are for the benefit of the dental student and are devoted to general surgery, the remaining ones treat the diseases of the mouth and jaws proper. A book of this kind is rare; as a text-book it is ideal, as a work of reference it may be warmly recommended to both the general and the dental surgeon.

L. E.

Text Book on the Pathogenic Bacteria and Protozoa. Seventh edition, thoroughly revised. A text book upon the Pathogenic Bacteria and Protozoa. For Students of Medicine and Physicians. By Joseph McFarland, M. D., Professor of Pathology and Bacteriology in the

Medico-Chirurgical College, Philadelphia. Seventh edition, thoroughly revised. Octavo of 878 pages, 293 illustrations, a number of them in colors. Philadelphia and London: W. B. Saunders Company, 1912. Cloth, \$3.50 net.

One must consider this book from the standpoint of the student, the practitioner, and the specialist. The text is absolutely inadequate in many places for the student, i. e., p. 182, in his description of Gram's method of staining, the essential details of this most important test are omitted. For the specialist the book is out of the question, being too inaccurate, indefinite, and inadequate. On the other hand it would be a fair book for the busy practitioner for reference and to give him a brief résumé of the literature to date. With a like number of other recent publications, the author has attempted to devote too much space to the more recent methods and conditions, in many ways neglecting more important "old" subjects. The bacteriological side of sanitation is neglected to a sad degree, this important branch of the subject being merely touched upon. A few of his experiments showing lack of detail are as follows: autoclave, p. 232; antiseptics, p. 302; Wassermann reaction, p. 334; stools in typhoid, p. 650.

The illustrations are to be commended, most of them being simple, clear, and easily understood. S. R. D.

New Aspects of Diabetes, Pathology and Treatment. By Prof. Dr. Carl von Noorden. Published by E. B. Treat & Co., New York. 1912. Price \$1.50.

This is the latest of the well-known red covered books with which this firm of publishers has kept the American medical public in touch with the work of von Noorden. This monograph covers a series of lectures delivered during October, 1912, before the New York Post-Graduate Medical School. Physicians and students in San Francisco had the opportunity of hearing two of these lectures (San Francisco County Medical Society, Oct. 15, 1912; Stanford University, Oct. 21, 1912), and they will surely welcome the opportunity of having these in permanent form. There are many points presented by von Noorden which differ from our older accepted views, the most radical being the one expressed as to the harmlessness of the ketonuria so often seen on changing to a strict diet, this being a source of great worry to the average physician who only too frequently sees in this an indication for the administration of carbohydrates. The relations of the various glands with internal secretions to the pancreas are interestingly shown, though it must be confessed that but little practical value so far as therapy is concerned, has resulted from this study.

The translation of these lectures leaves a great deal to be desired, especially the first chapters. Their perusal is thus deprived of a great deal of the pleasure which they would otherwise afford. It would seem as if the haste with which they were translated and published had something to do with this. To German readers we would recommend the sixth edition of von Noorden's "Die Zuckerkrankheit und ihre Behandlung," published by Aug. Hirschwald in Berlin, February, 1912, as being just as modern and far more comprehensive in scope. R. B.

The Practice of Dentistry. A practical treatise upon the general practice of Dentistry, Operative and Prosthetic, exclusive of Orthodontic Practice. By Leo Greenbaum, M. D., D. D. S.,

formerly Dean and Professor of Clinical Dentistry, Materia Medica and Anaesthesia, Philadelphia Dental College, and Max Greenbaum, formerly Quiz Master, Philadelphia Dental College. 350 illustrations. D. Appleton & Co., 1912.

The work is an effort to embrace nearly everything relating to modern dental practice in one book with the exception noted in the title. Chapters 1 and 2 on dentition present subject-matter not usually found in works on operative dentistry, and though the author may differ with medical opinion in therapeutic measures, basing his judgment on clinical experience, under present dental educational conditions it has some value. A review of the history of the cause of dental caries is followed by a statement of the generally accepted theories of to-day. Nothing new is presented in operative procedure under nomenclature, cavity preparation, or the use of filling materials, Dr. G. V. Black's recent work being quoted very largely. Many of the illustrations were published in dental text-books thirty years ago. Burchard's Dental Pathology and Buckley's Materia Medica and Therapeutics are quoted frequently in the chapters dealing with those subjects. In the treatment for the removal of the dental pulp, no mention whatever is made of novocain, so generally used in pressure, peridental, and intraosseous anesthesia. The chapter on Oral Hygiene for children might be of some interest to the medical practitioner. Section II on Prosthodontia is a more modern presentation, and deals very generally with all phases of this field of dental science, especially crown and bridge work. Quite all of the illustrations and descriptive matter on anatomical articulation appeared in Dental Digest in 1910 and later was donated to the profession in book form as a premium with a subscription to that journal. It is difficult to conceive of one's library being concentrated in a single volume.

GUY S. MILLBERRY.

TWO YEARS' INTERNESHIP—GOOD SAMARITAN HOSPITAL, GUANAJUATO, MEXICO.

This is a missionary hospital which was started by the Methodist Episcopal Church. Another Christian doctor is needed for the staff.

Guanajuato is a city of 60,000, the capital of the state of the same name. It is located 160 miles northwest of Mexico City. It stands at an altitude of 6,500 feet in a rich silver-mining region. The Mexican Central Railroad passes through the city.

One year's report of the hospital staff shows 339 visits to homes, 4,579 consultations, 24,523 treatments, 52 major and 279 minor surgical operations, medicines furnished 17,587 patients. Fifteen different nationalities were included among those who were treated.

For the internship a man is required who has had a thorough medical education and who is prepared to make his professional knowledge and skill directly subservient to the furtherance of the gospel.

Communications may be addressed to the director of the hospital, Dr. Levi B. Salmans, Good Samaritan Hospital, Guanajuato, Mexico.

The undersigned will be glad to communicate with any medical men who are interested in the need for physicians in foreign countries.

Mr. Wilbert B. Smith, 125 East 27th Street, New York City.

AN INTERESTING CIRCULAR.

Chicago, Dec. 12, 1912.

Members of the American Surgical Trade Association.

Gentlemen:—During the last month the postal authorities have made a very active campaign against persons and firms who are selling medicines and devices for the purpose of practicing "race suicide," and about 200 persons have been arrested in different parts of the country and are now being prosecuted.

In practically all surgical instrument catalogues there are certain pessaries, aluminum stems, etc., advertised for sale, which were originally designed for legitimate purposes, and therefore it occurred to your president, that some day an over-zealous official might swoop down on some of our members and prosecute them on account of selling these legitimate surgical instruments. In order to guard against such a contingency, I have asked our legal advisor, Mr. F. B. Hovey, to look up the law on this subject, and have a consultation with the Chief Postal Inspector, to clear up the situation. The law reads as follows:

"Everything designed or intended (or adopted) for the purpose of preventing conception or procuring abortion shall not be mailed."

We further are informed that the Inter-State Commerce Commission has also made a ruling that such articles cannot be sent by express from State to State. The inspector informed our attorney that the postal department has no judicial power and an absolute ruling could not be had unless the matter was put before headquarters in Washington. He believes, however, that any article that has been designed for a legitimate medical or surgical purpose other than prevention of conception, when sold to reputable physicians only, will not be made the basis of prosecution unless the present attitude of the postal authorities changes. It seems advisable, therefore, that we should instruct our salesmen when selling these instruments that they mention the fact that their firm sells them with the understanding that they be used only for the purpose for which they were originally intended. The sale of Mizpah or other pessaries of that type, fish skins, Neverrips, etc., are absolutely prohibited.

Respectfully,

V. MUELLER.

REPORT ON CONDITION OF ACCOUNTS OF STATE BOARD OF HEALTH.

January 6, 1913.

His Excellency, Hiram W. Johnson, Governor of California, Sacramento, Cal.:

Sir:—An audit of the accounts of the State Board of Health for the period beginning July 1, 1909, and ending June 30, 1912, has disclosed certain discrepancies and methods of doing business which it is deemed proper to call to your attention.

As a net result of the audit, Dr. W. F. Snow, Secretary of the Board, has been required to return to the funds of the State Board of Health a total of \$705.47 to cover discrepancies.

At the outset, it is the duty of this board to make plain to you that, although the Secretary had to return this amount, there is no suggestion of any criminal action on his part. The returning of this money by Dr. Snow is the direct result of the vicious system of transacting State business which had grown up in so many departments and institutions.

Some idea of the inefficiency of the old methods

and the confusion arising therefrom can be had from a knowledge of the fact that it took expert accountants the greater part of three months to reconstruct the records of the State Board of Health for the period of audit. In many instances the records were absolutely worthless, admitting of no check or countercheck and presupposing as a part of the system an accurate memory on the part of the person in charge.

The discrepancies making up the total of \$705.47 cover the entire period of the audit. There are so many and they are of such a variety that a recitation of them would be in effect a duplication of the report of the audit by the accountants. Therefore, a copy of the report is hereto attached and made a part of this special report.

Steps have been taken to properly formulate the business methods of the State Board of Health and to prevent recurrence of the discrepancies and confusion which have arisen under the old system.

Of the amount returned by Dr. Snow, \$329.14 has already been deposited to the account of the State Board of Health in the California National Bank. Herewith transmitted to you are a certified check for \$350 and a check on the Bank of Palo Alto for \$26.33 to cover the balance of the discrepancies.

This report is respectfully submitted this sixth day of January, 1913.

STATE BOARD OF CONTROL,
JOHN FRANCIS NEYLAN, Chairman.
CLYDE L. SEAVEY.
W. H. HUMPHREY.

Report Covering Affairs of State Board of Medical Examiners and Supplementary Report.

His Excellency, Hiram W. Johnson, Governor of California:

Sir:—The State Board of Control has completed an audit and investigation of the affairs of the State Board of Medical Examiners. The results of the audit and investigation are herewith respectfully submitted.

Enclosed you will find certificate of deposit numbered 2,942 of the Citizens' Bank of Alameda drawn in favor of Hiram W. Johnson, trustee, for the sum of \$1,324.40. This sum represents restitution to the funds of the medical board of certain amounts found short in the accounts of Dr. Charles L. Tisdale, secretary. The shortage of these funds, while important from a monetary standpoint, had an additional significance in view of the fact that it represents the unrecorded admission fees of thirty-nine physicians and surgeons in the State whose right to practice their profession could have been challenged.

Enclosed you will also find certain correspondence which came into the hands of accountants of the State Board of Control during their audit. Your attention is respectfully directed to this correspondence as it contains data which will throw light upon the methods formerly employed in conducting examinations of applicants for admission to the medical profession. These methods were employed by the former board of which Dr. Charles L. Tisdale was also secretary.

The period of audit extended from May 3, 1907, to March 18, 1912. The analysis of the records for this period shows that the method of handling the board's money was loose and that but little attention was paid by the board in general to its financial affairs, this being left in the hands of the secretary. Although the income was amply sufficient for its needs, the board almost constantly found itself in straitened circumstances.

This board, like others charged with the enforcement of vocational laws, expended large amounts for attorneys' fees and the returns were meager, with the exception of Attorney Frost, who seems to have rendered full value. The method of handling

the routine business of the board was cumbersome and inefficient, chiefly for the reason that it devolved largely upon the clerks employed under a co-operative agreement with a gentleman who was not a member of the board, but maintained adjoining offices.

The State Board of Control respectfully advises your Excellency that the loose methods which prevailed in the handling of the board's money could not have existed had these funds been deposited in the state treasury and paid out upon warrant of the Controller, as is done in the case of the administrative departments of the state government.

The detailed analysis of the accounts of the medical board shows that Dr. Tisdale did not record in his cash book or transmit to the treasurer of the board the statutory admission fees paid by thirty-nine applicants for license to practice in California.

An examination of the cash book shows that in certain instances the names of these applicants and the record of their payments had been made in the cash book and had been subsequently erased. These shortages in the cash book were then covered up by bulking the remittances to the treasurer of the board, who had no original data from which to check the amounts he had received. There was never any reconciliation of the books of the treasurer and secretary, hence the shortage never came to light.

This total of \$1,025 is the amount of fees received but unrecorded. In addition to this, an item of \$299.40 was missing from the records of the board. This was money collected in fines from illegal practitioners.

Under the method which has prevailed the medical board received and kept in possession of its secretary all revenue received from applicants for admission, which is the chief source of revenue. In cases of prosecution where fines were imposed, however, the money was transmitted directly from the county to the state treasury. Subsequently the secretary of the board drew on the treasury for the amount of the fines.

Fines aggregating \$300 had been deposited in the state treasury and on May 1, 1908, Dr. Tisdale drew a claim for this amount. The claim was allowed and the money, less sixty cents exchange, was transmitted to the Citizens' Bank of Alameda to the credit of Dr. Tisdale. Its receipt was never recorded on the books of the medical board.

This amount, in addition to the \$1,025 short in admission fees, makes the total of \$1,324.40 refunded to the treasury of the board by Dr. Tisdale. Because of the absence of records it is impossible to check the amount of money received in fines, and it is impossible to determine whether all fines were transmitted to the state treasury. The attorneys employed apparently made no report of prosecutions except in a few cases and the secretary of the board made none.

Attorney C. A. S. Frost, employed since July, 1910, was the sole exception. This gentleman rendered a report and examination of the records shows that as a result of his prosecutions approximately \$1,600 in fines was collected. His services cost the board \$2,074.25.

Eliminating the employment of Mr. Frost, it is found that more than \$8,000 was expended in attorneys' fees and the only collected fines recorded aggregate \$1,700.

Another feature of the records of the board which is interesting is contained in the record of per diems paid to members of the board which retired in 1909. On one occasion a member of the board sent his proxy to be voted by a confrere who was present. The vote was recorded by proxy, but the per diem records show that the absent member received \$21 as per diem.

Numerous other incidents could be quoted to

bring to the attention of your Excellency the utter lack of method or regard displayed in handling the business of the board. What influences were at work in the board will be apparent from the accompanying correspondence.

This report is respectfully submitted this 22d day of August, 1912.

STATE BOARD OF CONTROL,
JOHN FRANCIS NEYLAN, Chairman.
CLYDE L. SEAVEY.
FRED. C. NELLIS.

Supplemental Report.

Dec. 26, 1912.

His Excellency, Hiram W. Johnson, Governor of California.

Sir:—Pursuant to your instructions, I have completed a supplemental inquiry into the affairs of the State Board of Medical Examiners, and herewith respectfully resubmit the report of this board, together with the correspondence attached, and certain facts hereinafter set forth.

You are respectfully advised at this time that no evidence of substantial character has been brought to light which would tend to prove that any one but Dr. Tisdale profited by the transactions set forth in the original report. His admission that he alone profited, I believe, can be taken at its face value.

Supplemental inquiry has served to still further accentuate the fact that in these vocational boards created to regulate professions the business and financial details are left entirely in the hands of one or two members, and the remaining members neglect to give them even the slightest attention. The results of such neglect upon the part of other members are well exemplified in the conditions which prevailed in the former State Board of Examiners in Optometry, and in the medical board until its accounts were audited.

In view of the facts developed, I would respectfully urge upon you that legal provision should be made requiring all boards, bureaus, offices, or commissions empowered by law to collect money to deposit the same with the state treasury and disburse it in accordance with the usual procedure subject to the audit of this Board and of the State Controller.

I have completed this supplemental inquiry by having a member of the accounting department of this board thoroughly scrutinize all transactions since the completion of the former audit. The accounts have been found to be in proper condition during that time.

The final submission of this matter has been delayed because of the fact that as a member of this board, I have had to devote my entire time for eleven weeks past with the other members of the board to the preparation of the budget for the sixty-five and sixty-sixth fiscal years.

Respectfully,

STATE BOARD OF CONTROL,
JOHN FRANCIS NEYLAN, Chairman.

Summary of Results of Investigation of State Board of Medical Examiners.

1. Records of the board have been reconstructed and correct record made of all moneys received.
2. Petty grafting by secretary has been effectually stopped.
3. In original and supplemental reports complete data has been placed in the hands of His Excellency, Hiram W. Johnson, on which to fix responsibility for condition of board's affairs in the past.
4. The standing of thirty-nine physicians which was jeopardized by failure to record payment of their fees has been put beyond question.

BOARD OF EXAMINERS, DECEMBER, 1912, SESSION.

School of Medicine.	Passed.		Percentage.
	Date of Graduation.		
Coll. of P. & S., Med. Dept., Univ. of So. Calif.	6, 24, 09	85.1	
Coll. of P. & S., Med. Dept., Univ. of So. Calif.	6, 15, 11	81.3	
Coll. of P. & S., Med. Dept., Univ. of So. Calif.	6, 13, 12	80.1	
Coll. of P. & S., Med. Dept., Univ. of So. Calif.	—, —, 05	78.4*	
Coll. of P. & S., Med. Dept., Univ. of So. Calif.	6, 13, 12	78.2	
Coll. of P. & S., Med. Dept., Univ. of So. Calif.	6, 13, 12	77.6*	
Coll. Phys. & Surgs., San Francisco, Calif.	6, 6, 12	75. *	
Cooper Med. Coll., Calif.	5, 9, 12	81.	
Cooper Med. Coll., Calif.	5, 9, 12	75.8*	
Oakland Coll. Med. & Surg., Calif.	5, 28, 12	85.6	
Oakland Coll. Med. & Surg., Calif.	5, 28, 12	84.4	
Oakland Coll. Med. & Surg., Calif.	5, 28, 12	79.	
Oakland Coll. Med. & Surg., Calif.	5, 28, 12	78.3*	
Oakland Coll. Med. & Surg., Calif.	9, 2, 12	77.5	
Univ. of Calif., Med. Dept., Calif.	6, 20, 12	90.	
Univ. of Calif., Med. Dept., Calif.	6, 1, 11	86.1	
Univ. of Calif., Med. Dept., Calif.	6, 1, 11	85.4	
Univ. of Calif., Med. Dept., Calif.	6, 20, 12	82.9	
Univ. of Calif., Med. Dept., Calif.	6, 20, 12	82.5	
Univ. of Calif., Med. Dept., Calif.	6, 20, 12	81.1	
Albany Med. Coll., N. Y.	5, 19, 08	84.9	
Baltimore Med. Coll., Md.	4, 17, 00	86.3	plus 5-91.3
Central Coll. of P. & S., Ind.	—, —, 86	75.2	plus 10-85.2*
Chicago Med. Coll., Ill.	3, 30, 80	75.	plus 15-90. *
Coll. Phys. & Surgs., Chicago, Ill.	—, —, 91	77.4	plus 10-87.4
Cornell Univ. Med. Coll., N. Y.	6, 12, 07	86.4	
Creighton Med. Coll., Nebr.	4, 27, 12	79.9	
Denver & Gross Coll. of Med., Colo.	5, 18, 06	81.3	
Detroit Coll. of Med., Mich.	4, 19, 94	81.	plus 5-86. *
Drake Univ., Med. Dept., Iowa.	3, 17, 97	77.2	plus 5-82.2
Eclectic Med. Coll., Ohio.	4, 19, 05	77.8	
George Washington Univ., Dist. of Col.	6, 5, 12	86.2	
Harvard Med. School, Mass.	6, 28, 11	89.3	
Harvard Med. School, Mass.	6, 20, 12	83.5	
Harvard Med. School, Mass.	6, 20, 12	80.1*	
Medico-Chirurgical Coll. of Phila., Pa.	5, —, 95	76.8	plus 5-81.8*
Miami Med. Coll., Ohio.	3, 3, 73	66.7	plus 15-81.7*
New York Homeo. Coll. & Hosp., N. Y.	5, —, 04	77.1	
Northwestern Univ., Med. Sch., Ill.	6, 19, 02	80.8	plus 5-85.8
Northwestern Univ., Med. Sch., Ill.	6, 14, 11	81.5	
Ohio Med. Univ., Ohio.	5, 8, 06	80.2	
Rush Med. Coll., Ill.	3, 21, 12	85.8	
Rush Med. Coll., Ill.	6, 18, 02	81.2	plus 5-86.2
Rush Med. Coll., Ill.	6, 16, 05	80.6	
Rush Med. Coll., Ill.	3, 31, 91	79.	plus 10-89.
Rush Med. Coll., Ill.	5, 26, 97	76.5	plus 5-81.5
Toronto Med. Coll., Canada.	5, 9, 11	80.4	
Univ. of City of New York.	4, 7, 93	75.4	plus 5-80.4
Univ. of Colorado.	6, 7, 11	80.	
Univ. of Florence, Italy.	2, 11, 04	76.5	
Univ. of Genoa, Italy.	6, 6, 05	75.	
Univ. of Illinois, Coll. of Med.	6, 6, 11	85.8	
Univ. of Illinois, Coll. of Med.	6, 4, 12	84.4	
Univ. of Illinois, Coll. of Med.	6, 4, 12	88.	
Univ. of Illinois, Coll. of Med.	6, 4, 12	85.8	
Univ. of Illinois, Coll. of Med.	6, 4, 12	84.8	
Univ. Minn., Coll. Med. & Surg., Minn.	6, 9, 10	81.9	
Univ. Minn., Coll. Med. & Surg., Minn.	6, 5, 02	77.4	plus 5-82.4
Univ. of Penn., Pa.	6, 9, 97	82.6	plus 5-87.6
Univ. of Penn., Pa.	6, 13, 00	91.1	plus 5-96.1
Univ. of Penn., Pa.	6, 18, 02	83.3	plus 5-88.3
Univ. of the South, Tenn.	12, 1, 01	72.8	plus 5-77.8
Univ. of Virginia.	6, 14, 11	84.	
Vanderbilt Univ., Med. Dept., Tenn.	—, —, 08	86.7	
Vanderbilt Univ., Med. Dept., Tenn.	5, 21, 12	85.4	
Vanderbilt Univ., Med. Dept., Tenn.	3, 1, 91	81.5	plus 10-91.5
Western Reserve Univ., Med. Dept., Ohio.	3, 2, 92	84.4	plus 10-94.4
Wisconsin Coll. of P. & S., Wis.	5, 28, 03	75.8	
Woman's Hospital Med. Coll. of Chi., Ill.	4, 5, 87	77.8	plus 10-87.8
Failed.			
Coll. of P. & S., Med. Dept., Univ. of So. Calif.	6, 13, 12	65.7	
Baltimore Univ. Sch. of Med., Md.	—, —, 99	61.2	plus 5-66.2*
Barnes Med. Coll., Mo.	5, 16, 11	67.2	
Bennett Eclectic Coll. Med. & Surg., Ill.	5, 8, 00	67.4	plus 5-72.4
Central Med. Coll., Mo.	3, 1, 98	67.5	plus 5-72.5
Cleveland Univ. of Med. & Surg., O.	3, 23, 97	69.2	plus 5-74.2
Coll. Phys. & Surgs., Ill.	4, 21, 96	57.2	plus 5-62.2

Coll. Phys. & Surgs., Ill.....	4, 21, 96	69.1 plus 5-74.1
Eclectic Med. Inst., of Cinn., O.....	6, 3, 90	61.4 plus 10-71.4
Hahnemann Med. Coll., Ill.....	4, 13, 90	63.2 plus 10-73.2
Hahnemann Med. Coll., Ill.....	4, 26, 05	64.5
Lincoln Med. Coll., Nebr.....	8, 1, 06	69.2*
Louisville Nat. Med. Coll., Ky.....	5, 9, 89	42. plus 10-52. **
Missouri Med. Coll., Mo.....	3, 2, 81	41.4 plus 15-56.4
Omaha Med. Coll., Nebr.....	4, 4, 95	59.9 plus 5-64.9
Rush Med. Coll., Ill.....	5, 25, 99	70.7 plus 5-75.7
Rush Med. Coll., Ill.....	3, 25, 90	66. plus 10-76.
Rush Med. Coll., Ill.....	2, 20, 83	62.1 plus 10-72.1*
Tennessee Med. Coll., Tenn.....	5, 20, 08	56.6
Univ. Med. Coll., N. Y.....	3, 9, 86	61.4 plus 10-71.4
Univ. of Denver, Colo.....	5, —, 02	63.9 plus 5-68.9
Univ. of Louisville, Ky.....	6, 29, 05	70.5***
Univ. of Illinois, Coll. of Med., Ill.....	6, 4, 12	71.6
U. S. Grant Univ., Tenn.....	5, 1, 08	73.1
Willamette Univ., Med. Coll., Oreg.....	3, 28, 04	70.5

Osteopathy—Passed.

American Sch. of Osteopathy, Mo.....	5, 31, 10	77.7
American Sch. of Osteopathy, Mo.....	6, 3, 12	77.4
American Sch. of Osteopathy, Mo.....	6, 5, 11	77.3
American Sch. of Osteopathy, Mo.....	6, 22, 05	75.3*
L. A. Coll. of Osteopathy, Calif.....	1, 26, 12	82.9
L. A. Coll. of Osteopathy, Calif.....	6, 1, 11	80.3**
L. A. Coll. of Osteopathy, Calif.....	6, 6, 12	77.8
L. A. Coll. of Osteopathy, Calif.....	6, 6, 12	77.5
L. A. Coll. of Osteopathy, Calif.....	6, 2, 10	77.4
L. A. Coll. of Osteopathy, Calif.....	6, 6, 12	77.1
L. A. Coll. of Osteopathy, Calif.....	6, 1, 11	76.6
L. A. Coll. of Osteopathy, Calif.....	6, 6, 12	76.5
L. A. Coll. of Osteopathy, Calif.....	6, 1, 11	76.2**
L. A. Coll. of Osteopathy, Calif.....	6, 1, 11	75.4*
L. A. Coll. of Osteopathy, Calif.....	6, 6, 12	75.2*
L. A. Coll. of Osteopathy, Calif.....	6, 6, 12	75. *
L. A. Coll. of Osteopathy, Calif.....	6, 2, 10	75.
L. A. Coll. of Osteopathy, Calif.....	6, 1, 11	75. *
Pacific Coll. of Osteopathy, Calif.....	6, 20, 12	88.5
Pacific Coll. of Osteopathy, Calif.....	6, 20, 12	75.5

Osteopathy—Failed.

American Sch. of Osteopathy, Mo.....	6, 5, 11	36.3
L. A. Coll. of Osteopathy, Calif.....	1, 26, 12	71.3*
L. A. Coll. of Osteopathy, Calif.....	6, 6, 12	71.
L. A. Coll. of Osteopathy, Calif.....	1, 26, 12	70.6
L. A. Coll. of Osteopathy, Calif.....	6, 1, 11	70.3
L. A. Coll. of Osteopathy, Calif.....	6, 1, 11	70.2*
L. A. Coll. of Osteopathy, Calif.....	6, 6, 12	68.9
L. A. Coll. of Osteopathy, Calif.....	1, 26, 11	67.2****
L. A. Coll. of Osteopathy, Calif.....	6, 6, 12	65.7
L. A. Coll. of Osteopathy, Calif.....	6, 6, 12	64.3
L. A. Coll. of Osteopathy, Calif.....	6, 6, 12	63.6
L. A. Coll. of Osteopathy, Calif.....	1, 27, 10	63.5****
L. A. Coll. of Osteopathy, Calif.....	6, 6, 12	62.8
L. A. Coll. of Osteopathy, Calif.....	6, 6, 12	59.5
Pacific Coll. of Osteopathy, Calif.....	6, 20, 12	71.
Pacific Coll. of Osteopathy, Calif.....	6, 15, 11	66.9**
Pacific Coll. of Osteopathy, Calif.....	6, 20, 12	66.7*
Pacific Coll. of Osteopathy, Calif.....	6, 20, 12	58.5
Philadelphia Coll. & Infirmary of Osteopathy, Pa.....	6, 22, 05	71.2*
S. S. Still Coll. of Osteopathy, Mo.....	1, 29, 03	73.7

* Taken before.

New Licentiates—Medical Doctors.

A. W. Abbott, Albert Allen, S. M. Alter, J. H. Anderson, J. W. Bardill, F. J. Barnet, O. S. Bay, W. R. Boone, J. I. Boyer, O. W. Butler, J. M. G. Carter, F. H. Carter, E. S. Coburn, A. B. Cooke, C. C. Dickinson, A. B. Diepenbrock, W. W. Dill, J. B. Dodds, T. H. P. Duncan, E. V. Emery, C. C. Fitzgibbon, P. French, F. M. Gardner, E. J. Gay, C. M. Gouley, E. M. Hasty, F. L. Herrick, L. D. Hollingsworth, W. H. Holmes, K. Iseri, E. C. Jeancon, C. A. Jensen, A. N. Kerr, A. T. King, J. J. Klick, C. C. Landis, R. L. Larsen, W. E. Libby, E. M. Lundegaard, T. MacRae, J. H. Miller, E. D. Moffett, L. R. Moore, R. Moretti, C. H. Peppers, V. M. Pinkley, F. A. Phillips, R. Pollock, W. R. Reeves, C. G. Reum, D. N. Richards, B. Robbins, R. R. Ronan, A. H. Rosburg, J. M. Rose, F. M. Rossiter, E. H. Schneider, E. Scosseria, C. E. Shank, H. Shoemaker, G. M. Silverberg, J. H. Stark, W. F. Traugher, J. W. Truxaw, J. P. Vye, G. Walsh, G. H. Willcutt, F. C. Wiser, J. C. Yates.

New Licentiates—Osteopaths.

G. M. Bales, R. F. Buchman, E. Ellison, C. E. Faddis, S. W. Hutchinson, W. W. Hutchinson, M. P. Jason, H. P. Jelsma, E. F. Jerrue, P. B. Magill, C. C. Moreland, L. M. Mosher, M. Mossman, E. Pethe-ram, R. W. Shultz, L. B. Smith, C. F. Thwaites, L. A. Weaver, C. H. West, F. W. West.

New Licentiates—Honorably Discharged United States Surgeons.

Frampton Cove Brosius, Rush Med. Coll., Ill., Febr. 19, 1883; Wm. L. Whittington, Jefferson Med. Coll., Pa., April 4, 1888.

LANE MEDICAL LIBRARY.

Announcement of Hours.

The Lane Medical Library is open every day except Sunday from 8:30 a. m. to 5:30 p. m. and is open evenings from 7:30 to 9:30 except on Saturday. The library is open for the general use of the profession but it is anticipated that those who use the library often will contribute \$5 per year for the privilege of using the books in the library or \$10 per year for the privilege of taking the books home. Life memberships cost \$100.

WHEN IS A CURE NOT A CURE?

At a meeting of the French Society for Dermatology and Syphiligraphy, Gaucher told of a patient who got a cutaneous syphilid 50 years after a chancre. This was capped by Brocq, who observed a gumma in a man of 84: his chancre had been acquired at the age of 19, after which the syphilis had utterly vanished for 65 years.

EQUAL OPPORTUNITY AND THE SQUARE DEAL.

A negress, the wife of a white man, gave birth, in the Obstetric Clinic of the University of Munich, to twins, one of whom was black and the other white.

NEW AND NON-OFFICIAL REMEDIES.

Since March 1 the following articles have been accepted for inclusion with New and Nonofficial Remedies:

- Capsules of Holadin Succinate of Soda and Bile Salts (Fairchild Bros. & Foster).
- Capsules of Bile Salts Succinate of Soda and Phenolphthalein (Fairchild Bros. & Foster).
- Capsules of Holadin, Bile Salts and Phenolphthalein (Fairchild Bros. & Foster).
- Euscopol (Riedel & Co.).
- Ecodin (Riedel & Co.).
- Iodo-Casein (H. K. Mulford Co.).
- Iodo-Casein Tablets, 2½ grs. (H. K. Mulford Co.).
- Iodo-Casein Tablets, 5 grs. (H. K. Mulford Co.).
- Formicin (Kalle & Co.).
- L-Suprarenin Synthetic Bitartrate Tablets (V. Koechl & Co.).
- Colon Vaccine (Parke, Davis & Co.).
- Gonorrheal Vaccine (Combined) (Parke, Davis & Co.).
- Typhoid Vaccine (Prophylactic) (Parke, Davis & Co.).
- Furunculosis Vaccine (Parke, Davis & Co.).
- Combined Bacterial Vaccine (Parke, Davis & Co.).
- Acne Vaccine (Parke, Davis & Co.).
- Novocain Tablets "D" (Victor Koechl & Co.).
- Novocain Tablets "F" (Victor Koechl & Co.).
- Novocain Suprarenin Tablets "A" (Victor Koechl & Co.).
- Novocain Suprarenin Tablets "B" (Victor Koechl & Co.).
- Novocain Suprarenin Tablets "C" (Victor Koechl & Co.).
- Novocain Suprarenin Tablets "E" (Victor Koechl & Co.).
- Proferrin (H. K. Mulford Co.).
- Proferrin Tablets, 1 gr. (H. K. Mulford Co.).
- Proferrin Tablets, 2½ grs. (H. K. Mulford Co.).
- Proferrin Tablets, 5 grs. (H. K. Mulford Co.).
- Meningo-Bacterin (H. K. Mulford Co.).
- Tyramine (Burrroughs Wellcome & Co.).
- Tuberculin-Rosenbach (Kalle & Co.).

Since publication of New and Nonofficial Remedies, 1912, and in addition to those previously reported, the following articles have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association for inclusion with "New and Nonofficial Remedies."

Novatophan is ethyl 6-methyl-2-phenyl-quinolin-

4-carboxylate, $\text{CH}_3\text{C}_6\text{H}_4\text{N}(\text{C}_6\text{H}_5)\text{COOC}_2\text{H}_5$, 6:2:4, the ethyl ester of paratophan. It is a crystalline, tasteless powder, insoluble in water. Its action is the same as that of atophan from which it differs only in being tasteless. It is also furnished in the form of Novatophan Tablets, 0.5 Gm. (7½ grains). Schering & Glatz, New York (Jour. A. M. A., Nov. 30, 1912, p. 1971).

Hexal is hexamethylenamin salicylsulphonic acid, $(\text{CH}_2)_6\text{N}_4\text{C}_6\text{H}_4(\text{OH})\text{COOH.HSO}_3$. It is a white crystalline powder, soluble in water. It is a weak combination of hexamethylenamin and salicylsulphonic acid. It is claimed to have the action of hexamethylenamin combined with an anesthetic and astringent action on the inflamed mucous membranes of the biliary passages and urinary bladder, without having a deleterious effect on the bladder walls. Claimed to be useful in chronic inflammation of the bladder, posterior urethritis, etc. It is also furnished in the form of Hexal Tablets, 0.5 Gm. (7½ grains). Riedel & Co., New York (Jour. A. M. A., Nov. 30, 1912, p. 1971).

Glycotauro, Bile Salts, H. W. & Co., is concentrated ox bile, freed from bile pigments, each Gm. representing approximately 10 c.c. of fresh ox bile. It is a soft, semi-solid mass of bile-like odor and slightly bitter taste. Its actions and uses are those of bile salts. It is marketed in the form of Glycotauro Capsules, 5 gr. and Glycotauro Pills, 1 gr. Hynson, Westcott & Co., Baltimore, Md. (Jour. A. M. A., Dec. 7, 1912, p. 2066).

Mercurial Ointment, Improved, Mulford, is an ointment containing 50 per cent. of metallic mercury in an ointment base consisting of anhydrous wool-fat, petrolatum and suet, aromatized. Its actions and uses are the same as mercurial ointment, U. S. P., but it is devoid of the unpleasant odor of the official preparation and is said to be more readily absorbed. It is marketed in the form of Capsules Mercurial Ointment, Improved, Mulford, 30 grains, and Capsules Mercurial Ointment, Improved, Mulford, 60 grains. H. K. Mulford & Co., Philadelphia, Pa. (Jour. A. M. A., Dec. 7, 1912, p. 2066).

Cycloform, isobutyl para-aminobenzoate, is 2-methyl-propyl-4-amino-benzoate, $\text{C}_6\text{H}_4(\text{NH}_2)\text{COO.C}_6\text{H}_4\text{CH}(\text{CH}_3)\text{CH}_3$. It is closely related to anesthesin (ethyl aminobenzoate) and propaesin (propyl aminobenzoate). It is an odorless, crystalline powder, soluble in olive oil and only slightly soluble in water. Said to act on wound surfaces or mucous membranes as a superficial and prolonged anesthetic and as a mild antiseptic. Used as a dusting powder, 5 to 20 per cent. ointments, in suppositories and internally in doses of 0.1 Gm. to 0.2 Gm. (1½ to 3 grains). Farbenfabriken of Elberfeld Co., New York (Jour. A. M. A., Dec. 14, 1912, p. 2150).

NEW MEMBERS.

Dwight, Wilder, San Francisco.
Utter, J. W., Anaheim, Cal.
Domann, Arthur H., Orange, Cal.
Von Werthern, J., San Francisco.
Osborn, H. B., Fillmore, Cal.
Homer, R. W., Ventura, Cal.
Craig, Thornton, Capay, Cal.
Gray, E. E., Marysville, Cal.
Gray, A. E., Marysville, Cal.
Seid, M. J., San Francisco.
Moore, C. B., San Francisco.
Hulen, Vard H., San Francisco.

DEATHS.

France, J. M., Perris, Cal.
Beach, Eliza J., Pasadena.
Paterson, Wm. A., Santa Clara.
Magee, F. J., Eugene City, Oregon (formerly Santa Clara, Cal.).
Reynolds, Geo. E., Hayward.